

Auburn School District No. 408

ADMINISTRATION BUILDING ANNEX

502 FOURTH STREET NORTHEAST • AUBURN, WA 98002 • 253-931-4927

SUBJECT: ADMINISTRATION OF MEDICATION AT SCHOOL and SEVERE ALLERGIC REACTION

In order to administer medication at school, whether prescription or over-the-counter drugs, state law and school district policy *requires*:

1. **Written instructions from the doctor or dentist.**
2. Written permission from the parent.
3. Medication in the original container.
4. The permission and instructions are good for only one school year.
5. Medications are stored in a locked cupboard at the school. Medications that need to be carried by the student, such as an inhaler or EpiPen must be specifically ordered by the physician (i.e., “student is to carry inhaler at all times”).

The doctor or dentist must include the name of the medication, the dosage, the possible risks, and the reason the medication needs to be given at school. Often the provider can adjust dosage times so medications need not be given during school hours. This requirement applies to all forms of medications, even over-the-counter preparations.

The parent must include a note requesting that the medication be given at school. There are forms in each school office, or a simple note will be accepted. If you are unable to obtain a note signed by the doctor, you must come to the school office and personally administer the medication to your student. Any medication *must* come in the original container with the child's name clearly printed on it.

In the event your student experiences an *allergic reaction* (i.e., to bee sting, insect bite, food, medication) at school or on a field trip, school personnel will respond in the following manner:

1. The student’s condition will immediately be evaluated and first aid care given as needed.
2. If indicated, 911 will be called.
3. If the student has a history of a severe allergic reaction, it is highly recommended the student have an EpiPen at school with the necessary paperwork from your health care provider in place.
4. If the parent/guardian or emergency contacts are not available for consultation and if immediate observation or treatment is urgent (in the judgment of school authorities or emergency personnel), your student will be transported by ambulance to the nearest hospital emergency room.

Please contact the school nurse if you have questions regarding this or any other health concern.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name _____ Birth date _____

School _____ Grade _____

THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST

NAME OF MEDICATION

DOSAGE

METHOD OF ADMINISTRATION

TIME OF DAY TO BE TAKEN

Diagnosis _____

Reason for medication to be given during school hours _____

If given PRN, specify the length of time between doses. *Indicate if student must carry inhaler on his/her person.*

Anticipated action _____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above-named student be administered the above-identified medication in accordance with instruction indicated above for the period commencing with the _____ day of _____, 20____, through the _____ day of _____, 20____ (*not to exceed current school year*) as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

Physician's/Dentist's Signature

Date of Signature

Printed Name

Phone Number

Address

THIS PORTION OF THE FORM IS TO BE COMPLETED BY PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above-identified student and request and authorize the school to administer the above-identified medication to the above-identified student in accordance with the prescription or doctor's instructions for the period beginning with the _____ day of _____, 20____ through the _____ day of _____, 20____ (*not to exceed current school year*). I also understand that the School Nurse may contact the prescriber regarding question related to this medication.

Medication must be supplied to the school in the original container.

Parent's/Guardian's Signature

Date of Signature

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Phone Number: Home/Work (please include area code)