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.

Office of Health Services
Auburn School District No. 408
Auburn, Washington

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name ______________________________________ Birthdate ____________________

School ____ Grade __________

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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.*

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Anticipated action ____

Possible side effects of medication ____________________________________

Emergency procedure in case of serious side effects ______________________

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I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated above from______________(date) to _______________(date) (*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

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Address

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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 from_____________(date) to _____________(date) (*not to exceed current school year*). I also understand that the School Nurse may contact the prescriber regarding questions related to this medication.

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

______________________________________ ____________________
Parent's/Guardian's Signature Date of Signature

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

HS 860 (07/07)