School Fax_____ revised 1/21/09

Kent School District
Kent, Washington
Authorization For Administration of Oral Medication at School

Student's Name_____ Birthdate_____

School_____ Teacher_____ Grade_____

Note: A medication dosage could be delayed or missed due to unexpected circumstances or changes in the student's schedule.

(This portion to be completed by the physician)

Name Of Medication	Dosage	Method of Administration	Time of Day To Be Taken
1.			
2.			

Reason for medication to be given during school hours_____

Anticipated action_____

Possible side effects of medication_____

Emergency procedure in case of serious side effects notify parents, if emergent call 911

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing with the first day of September, ____(year) through the last day of June, ____ (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.

Date of Signature

Licensed Health Care Provider's Signature

[ ] Robert T. Smithing, ARNP [ ] Kathleen F. Kleiver, ARNP
[ ] Madeline D. Wiley, ARNP [ ] Kathryn A. Swartz, ARNP
[ ] ~~Nan V. Walker, ARNP~~

253.859.2273
Telephone Number

Name

253.850.8894
Fax Number

FamilyCare of Kent, 10024 SE 240th St, #201, Kent, WA 98031
Address

This portion of the form is to be completed by the 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 doctors instructions for the period beginning the _____day of_____,____(year) through the _____ day of_____, _____ (year) (not to exceed one school year). ***I have read the medication policy and procedures outlined on the back of this form***. I also understand that the school nurse may contact the prescriber regarding questions related to this medication.

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

Date of Signature

Signature

Telephone Number Home Work

(Medication Policy on the reverse Side)