HIGHLAND SCHOOL DISTRICT 203

MEDICAL AUTHORIZATION TO DISCONTINUE MEDICATION AT SCHOOL

SCHOOL: _____ **YEAR:** _____

STUDENT: _____
DOB: _____ **AGE:** _____ **GRADE:** _____
PARENT/GUARDIAN (PRINT): _____
MEDICATION: _____ **HEALTH CONDITION**: _____

PARENT/GUARDIAN SECTION SECCION DE PADRE/GUARDIAN

My student no longer needs this medication to be given at school. If this medication was needed to treat a potentially life-threatening condition, I understand that I must provide the signature of the prescribing licensed health care provider below to verify that the medication is no longer needed. Without this signature, my student may be at risk for exclusion per **RCW 28A.210.320**.

*Mi estudiante ya no necesita este medicamento para ser impartido en la escuela. Si era necesario este medicamento para tratar una potencialmente vida amenazante, entiendo que yo debo proporcionar la firma de nuestro proveedor de cuidado de la salud abajo para verificar que esta medicación ya no es necesario. Sin esta firma, puede ser mi estudiante está en riesgo de exclusión por **RCW 28A.210.320**.*

Additionally, I will notify the school nurse if my student's health care needs change in the future.

Además, notificaré a la enfermera la escuela si la salud de mi estudiante cambia en el futuro.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**
Firma del padre *Fecha*

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

Debe ser completado por el proveedor de cuidado de la salud

I confirm that (student name): _____
No longer needs the following medication at school.
Name of medication: _____
Reason medication is being discontinued: _____

LHP Signature: _____ Date: _____

LHP printed name: _____ Phone: _____

Fax: _____

Please return this form to the school nurse.

Lo regresa a la enfermera de la escuela.

If you have any questions, please contact Highland School District.