PERMISSION TO ADMINISTER MEDICATION AT SCHOOL
HIGHLAND SCHOOL DISTRICT

Marcus Whitman Elementary PH: 509-678-8900 FAX: 509-678-5494 Tieton Intermediate PH: 509-678-8700 FAX: 509-678-2771
Highland Junior High / Highschool PH: 509-678-8800 FAX: 509-678-4140

SCHOOL: _____

STUDENT: _____ **DOB:** _____**GRADE:** _____

PARENT/GUARDIAN SECTION SECCION DE PADRE/GUARDIAN

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare instructions. I give permission for the following medication information to be shared with school staff on a "need to know" basis.
Yo pido que la enfermera o personal designado, le administer el medicamento recetada de acuerdo con las instrucolones del medico. Doy permiso que la siguiente informacion sea compartida con el personal escolar que necisita estar informado.

FOR INHALERS AND EPIPENS ONLY (PARA INHALADORS Y EPIPENS SOLAMENTE):

I give permission for my student to carry his/her emergency medication. _____ _____
Doy permiso papa mi estudiante pueda traer su medicamento emergencia. Yes/ Si No

My student is trained to self-administer their own emergency medication _____ _____
Mi estudieante tiene conocimiento y entrenamiento de adminitrarse su proplo Yes/ Si No
Medicimenato de emergencia.

_____	_____	_____ / _____	
Parent/Guardian Signature	Date	Home Phone	Emergency phone
Firma de Padre/Guardian	Fecha	Telefono de Casa	Telefono de Emergnecia

HEALTH CARE PROVIDER SECTION

Diagnosis for which medication is to be given during school hours: _____
Asthma Diagnosis: _____Mild intermittent _____ Mild persistent _____ Moderate persistent _____ Severe persistent

_____	_____	_____	_____
Name of Medication (1 per form)	Dosage	Method of administration	Time of day to be given

If given prn, specify length of time between doses: _____

Other directions for use: _____

Possible side effects: _____ Emergency action: _____ or _____911
Duration of order (Must choose one)

_____ Medication is ordered for duration of current school year (which may include summer school) Year: _____
_____ Medication to be given from _____/_____/_____ to _____/_____/_____

FOR INHALERS AND EPIPENS ONLY:

May this student carry his/her emergency medication? _____YES _____ NO
Is this student trained to self-administer his/her own emergency medication? _____YES* _____NO
*If yes, this student has received instruction in the correct and responsible way to use the medication.

FOR STUDENTS WITH ASTHMA OR ANAPHYLAXIS: The HCP must submit
"A written treatment plan for managing Asthma or Anaphylaxis episodes of the student and for Medication use by the student during school hours" RCW 28A.210.370.

HCP signature: _____ Date: _____

HCP Printed name: _____ Phone: _____

ONE FORM FOR EACH MEDICATION **revised June 2022**