Snoqualmie Valley
Public Schools

PHYSICIAN'S ORDERS FOR MEDICATION AT SCHOOL

Return Fax #: ____________________ ATTN: School Nurse-______________________

The following section is to be completed by the PARENT/ GUARDIAN:

Student:_______________________________ **Date of Birth**___________________________ **Grade**: ____
School/Teacher:____________________________

I request that the principal, or a staff member designated by her/him, be permitted to dispense the physician authorized medication as described below. I also give my permission for the exchange of information between the school district staff and the health care provider listed below. I understand that the medication is to be furnished by me in its original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of health care provider. I understand that my signature below indicates my understanding that the school accepts no liability for reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only.
If my child's physician or authorized prescriber authorizes the student to medicate himself/herself at school, I, the parents/guardian, shall hold harmless and indemnify the school and Snoqualmie Valley School District's officers, employees and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by the above named student.
If necessary the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed by the school nurse. I am the parent or legal guardian of the child named. According to state law no distinction will be made between prescription and over the counter medication. Therefore, A "Physician's orders for Medication at School" form must be signed by parent/guardian and physician for over-the-counter and prescription medicines.

_________ ____________________________________ _____________________ __________________
Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

The following section is to be completed by the PHYSICIAN or AUTHORIZED PRESCRIBER:

Name of Student: ___________________________________
Reason for which medication is given: ____
Name of Medication: _______________________________________ **Strength** ____________________________
Dosage: _____________________ **Scheduled times to be given/Frequency**: ____________________________
Form of medication/ treatment:
_____Tablet/Capsule ___ Liquid ___Inhaler ____ Injection ____ Nebulizer
____Other ___________________
If medicine is to be given **PRN** or **WHEN NEEDED**, describe indications:
____
Is child authorized to medicate himself/herself? ____ **YES** ____**NO**
This student may carry Asthma Inhaler/ Epipen: _________YES _______NO
If **YES**, I have instructed this student in the purpose and appropriate method or frequency of use; and student demonstrates necessary skill to use the medication and to use any device necessary to administer medication.
List restrictions and/ or significant side effects: ____
No side effects anticipated: ____________ Special storage requirements: _____________________________
Start Date: ________________ Stop Date: _____________/ End of School Year
For episodic/ emergency events only: ________________
Date: ____________ Physician or authorized prescriber's Signature: _________________________
Printed Physician name: _________________________________ Phone: ____________________
Fax number: __________________ Address: ____