SPECIAL SERVICES

12828 N Newport Hwy • Mead WA 99021 • Telephone (509) 465-7600 • Fax (509) 465-7646

MEDICATION REQUEST FORM

Student Name:____ Birthdate:_________________________

School:____ Grade: ___________________________

TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication(s)	Dosage(s)	Reason for Medication(s)	Time(s) of Day To Be Taken

If given prn, specify the length of time between doses: ____________________________________

Inhalers: This student has demonstrated, to a licensed health professional in my office, the ability to correctly administer this medication: ☐ Yes ☐ No

Student may carry inhaler on his/her person: ☐ Yes ☐ No

EpiPens: This student has demonstrated, to a licensed health professional in my office, the ability to correctly administer this medication: ☐ Yes ☐ No

Student may carry an EpiPen on his/her person: ☐ Yes ☐ No

Non-oral medication (i.e. eye drops, ointments): Student is capable of self-administration: ☐ Yes ☐ No

Possible side effects of medication: ____

____

I request/authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____________________to _________________ (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 school personnel who have no formal medical education.

_________________________ ____

Date of signature Signature (Licensed Health Professional with Prescriptive Authority)

Phone Number: _____________ Name: ______________________________________

(Print or Type)

NOTE: This form MUST be signed by a licensed health professional with prescriptive authority.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to be above-identified student in accordance with the doctor's instructions for the period from ____________________to _________________ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

Permission to carry inhaler: ☐ Yes ☐ No
Permission to carry EpiPen: ☐ Yes ☐ No
Permission to self-administer non-oral medication: ☐ Yes ☐ No

Date of Signature__________________ Parent/Guardian Signature_____________________________

Telephone Number: (Home)___________________________ (Work) ________________________