Olympia School District

AUTHORIZATION FOR STUDENT TO CARRY AND SELF-ADMINISTER MEDICATION AT SCHOOL AND/OR ON A SCHOOL-SPONSORED FIELD TRIP

Student's Name: _____ **Date of Birth**: _____

School: _____ **Grade**: _____

The following authorization must be completed and signed by a licensed Health Care Professional AND parent/legal guardian. Upon receipt, approval by the Principal and School Nurse is required.

I request and authorize the above named student to carry and self-administer the identified medication in accordance with instructions given to the student and parent/legal guardian from _____ to _____. There exists a valid health reason, which makes administration of medication advisable during such time that the student is under the supervision of school officials.

Name of Medication: _____

Dosage: _____

Method of Administration: _____

Time of day to be taken: _____

Licensed Health Care Professional's Signature: _____ Date: _____

Print Name: _____ Phone: _____ FAX _____

Address: _____

I certify that I am the parent/legal guardian of the above identified student. I request and authorize the above named student to carry and self-administer the identified medication in accordance with the prescription and instructions from the licensed health care professional listed above.

I further understand and agree that misuse or distribution of the authorized medication may result in disciplinary action as noted in Olympia School District Policy 3240. Permission is granted to exchange medication information with the principal, school nurse and supervising staff and between the school nurse and authorizing licensed health care professional.

NOTE: All medications MUST be supplied in the original container and the written authorization must match exactly with information on the container.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____ Phone: _____

School Nurse: _____ Date: _____

School Principal: _____ Date: _____

Valid for: _____ **Semester, 20**_____