

Medical Lake School District

116 W Third Street, PO Box 128
Medical Lake, WA 99022



Phone: (509) 565-3100
FAX (509) 565-3102 www.mlsd.org

PARENT INFORMATION: MEDICATIONS AT SCHOOL

Dear Parent/Guardian,

Your child's safety and the safety of others is our primary concern when medication is needed during school hours. Whenever possible, medications should be administered at home, outside of school hours.

The following requirements must be met if trained school personnel administer medication to your child during the school day (RCW 28A.210.260.270):

1. **Oral medication, topical medication, eye drops, ear drops or nasal sprays** may be administered by trained school staff.
 - No medications requiring injection shall be administered by unlicensed school personnel except for automatic injector pens ordered for an emergency allergic reaction (i.e. Epi-Pen or Auvi-Q)
 - Contact your school nurse if assistance with non-oral medications or other types of treatments are needed, as these may require specialized training.
2. **Medication must be delivered by the student's parent/guardian or other responsible adult.**
 - Please allow time for school staff to count pills/capsules with you.
 - If half pills are needed, parents must split them prior to delivering medication to staff.
3. **A *Medication Request Form* must be completed** before any medication, prescription or over-the-counter, can be given by school staff. This form is available from the school office or at: www.mlsd.org (Our District/Forms and Policies). Additional forms are required for children with Asthma, Diabetes and/or Severe Allergies.
 - This form must be **completed and signed by the student's LHP (Licensed Health Care Provider)**.
 - This form must be **completed and signed by the student's parent/guardian**.
 - A form must be submitted for each medication, **including over-the-counter medications** such as pain relievers, cough drops, cold medicines and sunscreen.
 - The completed medication request form can be hand delivered, mailed or faxed to school.
4. **All medication must be in a properly labeled container.**
 - Prescription medication must be in a container labeled by a pharmacist or physician with the correct name of medication, dosage and time for school administration.
 - Over-the-counter medication must be in its original container, unexpired, and labeled with your child's name.

MEDICAL LAKE SCHOOL DISTRICT #326

MEDICAL LAKE, WA 99022

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

STUDENT NAME: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE: _____

DO NOT use this form for students needing emergency medications for Asthma or Severe Allergy/Anaphylaxis at school. An Asthma or Severe Allergy Plan, which includes medication orders, is required (RCW28A.210.320+370). Plans are available from the school office or district website: www.mlsd.org (Our District tab/Forms and Policies).

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

MEDICATION	DOSAGE	METHOD OF ADMINISTRATION	TIME(S) TO BE GIVEN

Diagnosis or reason for medication: _____

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize this student to carry their medication Yes _____ No _____

I request and authorize this student to self-administer their medication Yes _____ No _____

The student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

I request and authorize the above named student be administered the above identified medication in accordance with the instructions indicated above from (date) _____ to (date) _____ or the entire 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 supervision of school officials. Medication orders are valid for the current school year only.

Date of Signature: _____ Licensed Health Professional: _____

Phone: _____ Fax: _____ LHP Printed Name: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the Licensed Health Professional.
- I give Health Services Staff permission to communicate with the medical office about this medication.
- I understand oral medications may be administered by non-licensed staff members who have been trained and supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 personnel if they are called.
- All medication supplied must be brought to school in **the original container** with instructions as noted above by the Licensed Health Professional.

I request and authorize my child to carry and/or self-administer their medication Yes _____ No _____

Date of Signature: _____ Parent/Guardian Signature: _____

Telephone Numbers: (home) _____ (work) _____

Student Name: _____

School: _____

MEDICATION ACCEPTANCE LOG

Date	No. of Pills	Witness Sign	Date	No. of Pills	Witness Sign

Date	Comments	Date	Comments