

**SNOQUALMIE VALLEY SCHOOL DISTRICT #410
PHYSICIAN'S ORDERS FOR MEDICATION AT SCHOOL**

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee in the absence of the school nurse. According to state law no distinction will be made between prescription and over the counter medication.

The school accepts NO RESPONSIBILITY for reaction when the medication is dispensed in accordance with the physician's directions.

Date form received by the school: _____ Student: _____

Date of birth, or age: _____ Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Is it necessary to dispense this medication during school hours: _____ Yes _____ No

Reason for medication: _____

Name of medication: _____ Strength _____

Form of medication/treatment:
_____ Tablet/capsule _____ Liquid _____ Inhaler _____ Injection _____ Other

Dosage _____ Scheduled times to be given _____

Special Instructions:

Start: _____ date form received Other date: _____
Stop: _____ end of school year Other date/duration: _____
For episodic/emergency events only: _____

Restrictions and/or important side effects: (If yes please describe) _____

No side effects anticipated _____
Special storage requirements: _____ None _____ Refrigerate

This student may carry Asthma Inhaler: _____ No _____ Yes

Date: _____ **Doctor's Signature:** _____

Please Print: Physician's Name: Address: Phone Number: ()
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Parental authorization on back of form

PARENTAL CONSENT

To be completed by parent/guardian

I request that the principal, or a staff member designated by her/him, be permitted to dispense to my child (name of child) _____ the medication prescribed by (name of physician) _____ for a period from _____ to _____
School Attending: _____

Please specify below how you want us to handle noon medications on early dismissal days:

- Yes, please give my child his/her medication before leaving school on early dismissal days.
- No, I do not want medication given to my child before leaving school on early dismissal days.

The medication is to be furnished by me **in the original container, labeled by the pharmacy or physician, with the name of the medicine, the amount to be taken, and the times of day to be given. The physician's name must be on the label.** Over the counter medication must be in the original container with label, directions, and expiration date clearly legible. I understand that my signature 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 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. I am the parent or the legal guardian of the child named.

Date: _____ Signature of parent/guardian: _____

Student's home address: _____ Phone #: _____

Pursuant to Snoqualmie Valley School District Policy #3416

ADDITIONAL INFORMATION
(TO BE PROVIDED BY PHYSICIAN)