PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

District	School	Fax	Phone
THORP	THORP	509-964-2313	509-964-2107

Student: _________________________________ **Birthdate:** ______________ **Grade:** _________

PARENT/GUARDIAN SECTION * *SECCION DE PADRE/GUARDIAN*

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions and give permission for the medication and care plan information to be shared with school staff on a "need to know" basis. *Yo pido que la enferma o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del medico y entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.*

I also give my permission to initiate a Section 504 Plan ***Yes*** ☐ ***No*** ☐
(See Parent Student Rights Form attached)
Doy permiso para iniciar la Sección 504 Plan ***Sí*** ☐ ***No*** ☐
(Ver formulario adjunto)

____________________________ ____________________ ______________________________

Parent/Guardian Signature — Date — Home phone / Emergency phone
Firma de Padre/Guardian — *Fecha* — *Teléfono de Casa* *Teléfono de Emergencia*

HEALTH CARE PROVIDER SECTION

Diagnosis for which medication is to be given during school hours: ____________________________________

Signs or symptoms for which medication should be administered ___________________________________

____

______________________ _______________ ________________________ ____________________

Name of medication (1 per form): **Dosage:** **Method of administration:** **Time of day to be given:**

*If given **prn**, specify length of time between doses:* ____

Other directions for use: ____

Possible side effects:________________________________Emergency Action:___________________or ☐ 911

Duration of Order (must choose one)

☐Medication is ordered for duration of current school year (which may include summer school)
☐Medication to be given from _____/_____/_____ to _____/_____/_____.

____ ___________________________
HCP Signature — Date

____ ___________________________
HCP Printed Name — Phone