Walla Walla Public Schools
Health Services Department

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student ______________________ Birthdate ______________

School ______________________ Grade ______________

THIS PORTION TO BE COMPLETED BY PHYSICIAN
(one medication per form, please)

NAME OF MEDICATION	DOSAGE	METHOD OF ADMINISTRATION	TIME OF DAY TO BE TAKEN

Reason for medication to be given during school hours: ______________________

____

Anticipated action ______________________

Possible side effects of medication ______________________
Emergency procedure in case of serious side effects ______________________

____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing with the 1st day of school , ____, through the last day of School , ____, 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 medically untrained school personnel.

☐ **At the physician's request, the student may carry on his/her person an Epi-pen or inhaler.**

☐ **For emergency situations, the student has been trained and is capable of self-administration.**

Date of Signature ______________ Physician's/Dentist's Signature ______________

(We recommend that PA orders be countersigned by the supervising physician.)

Name (Print or Type) ______________

Address ______________ Phone Number ______________

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or doctor's instructions for the period commencing with the ________ day of ____________, 20___, through the ________ day of ____________, 2_____ (not to exceed one year).
Medication will be supplied to school in the original Rx container.

☐ **The above identified student has been instructed to carry an Epi-pen or inhaler with him/her in case of emergency. PLEASE ADVISE STUDENT TO IMMEDIATELY REPORT TO THE SCHOOL NURSE FOR FURTHER EVALUATION.**

Date of Signature ______________ Parent/Guardian Signature ______________

Telephone: (work) ____________ (home) ____________