revised 8/09

Fax: 253-850-8825

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Rainier Christian Schools
Kent View Elementary
Authorization for Administration of Oral Medication at School

Student's Name____ Birthdate______________________________

Teacher__________________________ Grade____________________

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(This portion to be completed by the physician)

Name Of Medication	Dosage	Method of Administration	Time of Day To Be Taken
1. ______________________	__________	__________________________	______________________
2. ______________________	__________	__________________________	______________________

Student ____ May ____ May Not carry and self-administer this medication. Initials: _____ *(Non-controlled substances only)*

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______ day of _________________, ________ (year) through the _______ day of ______________ , ________ (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 the supervision of school officials. Such medication may be administered by medically untrained school personnel.

_____________________________________ Date of Signature

_____________________________________ Licensed Health Care Provider's Signature

_____________________________________ Telephone Number

_____________________________________ Name

_____________________________________ Fax Number

_____________________________________ Address

This portion of the form is to be completed by the 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 doctors instructions for the period beginning with the _______ day of ___________ , ________ (year) through the ________ day of ___________, _______ (year) (not to exceed one school year).

Medication MUST be supplied to the school in the original container.

____________________ Date of Signature

_____________________________________ Signature

_____________________________________ Telephone: Home Work Cell

_____________________________________ E-mail Address