Order is valid for entire 20__ - 20__ school year to include summer school

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Time(s)</th>
<th>Diagnosis for Medication</th>
<th>Common Side Effects</th>
<th>72-hour Disaster Preparedness</th>
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Pursuant with RCW 28A.210.260, RCW 28A.210.270, and RCW 28A.210.275, this form is an official request, and includes instructions to administer medications at school. It is signed by a legal guardian or parent and a licensed health care provider prescribing within their prescriptive authority. There exists a valid health reason which makes administration of such medication advisable during the hours when school is in session. This/these medication(s) may be administered by an employee designated by or pursuant to the school board policies. A parent designated adult as defined in RCW 28A.210.260 may administer medications. When the conditions specified in RCW 28A.210.260 have been substantially complied with, then the employee, the school district or school, and the members of the governing board, shall not be liable in any criminal action or civil damages as a result of the administration of medication.

Each medication needs to be properly labeled in the container it originated in, and must be labeled with the student’s name, date, quantity, and strength per dose unit, Licensed Health Provider name, frequency of administration, and other instructions for administration.

Medications need to be delivered directly to appropriate school personnel from parent or legal guardian. For self-administration (epinephrine and quick relief inhaler only), the student may have to demonstrate they have been instructed in the correct and responsible use of the medication to the appropriate school personnel. It is understood that after treatment for anaphylaxis, emergency services will be contacted for further treatment.

_________________________________________                   ____________________________________
Provider Name                                                                             Provider Signature

____________________                    __________________________          __________________________
Date                                    Contact Number                                    Fax Number
Authorization for Administration of Medication at School

By signing this form, I agree to all of the above information and I am explicitly requesting that a nurse or parent designated adult administer medication to my child while under the care of the school.

_________________________________________                   ____________________________________
Parent/Legal Guardian Name                                                       Parent/Legal Guardian Signature

________________________
Date                                                    Parent/Legal Guardian Primary Contact

________________________
Parent/Legal Guardian Secondary Contact

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