CHEHALIS SCHOOL DISTRICT
LEARNERS TODAY. LEADERS TOMORROW.

MEDICATION REQUEST

- ☐ James W Lintott Elementary (K-2) Fax 360-748-6167
- ☐ Orin C Smith Elementary (3-5) Fax 360-740-1952
- ☐ Chehalis Middle School (6-8) Fax 360-740-1849
- ☐ WF West High School (9-12) Fax 360-748-3664
- ☐ Lewis Co. Alternative School Fax 360-748-8899

STUDENT NAME:_____ **BIRTH DATE:**_____
SCHOOL:_____ **GRADE:**_____

DO NOT use this form for students needing emergency medications for Asthma or Anaphylaxis at school. An Asthma or Anaphylaxis Action Plan, which includes medication orders, is required (RCW 28.A210.370). Plans are available from the school office.

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication*	Dosage	Method of Administration	Time(s) to be administered

***One medication per request form- prescription and over the counter medications require this form be completed**

Reason for medication:_____

For As Needed medications, specify the minimum length of time between doses: _____

Possible side effects and action needed if noted at school: _____

For short term inhaler treatment for respiratory infection: In my office, this student has demonstrated the ability to correctly self-administer this medication (inhaler or other device) and may carry the medication on his/her person. Yes No N/A

I request/authorize the above named student be administered the above named medication in accordance with the instructions indicated above from _____ to _____ or the entire school year including summer months (if applicable), as there exists a valid health reason which makes administration of medication advisable during school hours. **Medication orders are valid for the current school year only.**

_____
Licensed Health Professional's Signature **Date**

_____ _____ _____
Phone number **Fax number** **Licensed Health Professional's Name (print)**

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I request/authorize trained school staff to administer medication to my child in accordance with the Licensed Health Provider's instructions above for the dates of _____ to _____ or one entire school year including summer months (if applicable).
Medication orders are valid for the current school year only.
I understand that a medication dosage could be delayed or missed due to unexpected circumstances or changes in the student's schedule.
I also give my permission for the exchange of information between School District Nurse and Licensed Health Professional for the purpose of clarifying medication orders/concerns that could affect safe administration at school.
The medication is to be furnished by parent/guardian in the original container, labeled by the pharmacy, with the name of the medication, dosage to be taken, and the time of day to be taken.

For short term inhaler treatment for <u>respiratory infection</u>:
My child will carry inhaler on his/her person and is trained and capable to self-administer. Yes No N/A
If so, I will provide a second "back up" inhaler for school. Yes No N/A

Note: If you child requires medication for asthma or anaphylaxis, contact your School Nurse. An Asthma or Anaphylaxis Plan which includes medication orders is required.

The district shall incur no liability as a result of any injury arising from the self-administration of medication.

_____
Parent/Guardian Signature **Date**