

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

District Toppenish	School	Fax (509) 865-2178	Phone
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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 _____