White Pass School District No. 303
Elementary 360.497.7300
Jr./Sr. High 360.497.5816

AUTHORIZATION FOR ADMINISTION OF MEDICATION AT SCHOOL

Student Name: _____Grade: _____ Birth date: _____

THIS PORTION TO BE COMPLETED BY THE MEDICAL PROVIDER

Name of Medication	Dosage	Method of administration	Time of day to be taken

If given PRN, specify the length of time between doses:_____

What observable side effects do you want us to report: _____

I request and authorize that the above named student be administered the above identified Medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year), as there exists a valid health reason with makes administration of the medication advisable during school hours.

_____ _____
Date of Signature Medical Provider Signature

_____ _____
Telephone Number Name (Print or Type)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the medical provider's instruction for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. The **medication is to be furnished by me in the original container** labeled by the pharmacy or medical provider with the name of medicine, the amount to be taken, and the time of day to be taken.

_____ _____
Parent/Guardian Signature Date of Signature

_____ _____
Home Phone Number Work Phone Number