Mercer Island School District

4160 86th Avenue SE • Mercer Island, WA 98040

MEDICATION AUTHORIZATION FORM

Student Name:_____ School: _____ Grade:_____ DOB: _____

Parent/Guardian: _____ Phone (Hm): _____ (Wk):_____

Mercer Island School District No. 400 is authorized by RCW 28A.210.260 State Statutes to administer any prescribed and over the counter medications to students during school hours, only when: 1) The medication is accompanied by a written, current, and unexpired request from a licensed medical health care provider, and 2) there exists a valid health reason that makes administration of the medication advisable during school hours. 3) For injectable medications, the Parent Request & Medical Health Care Provider Orders for Specialized Medical Treatment form is also required.

Medication requests will be valid only for the medication(s) listed and the dates indicated on District request forms. Requests shall not extend beyond the end of the current school year. Medications must be supplied in their original container with the label indicating the student's name, the licensed medical health care provider's name, the dosage, and instructions for administration. Medication may be administered by non-licensed/non-medical school personnel.

When a parent/guardian, medical health care provider, and school nurse agree, a student may be allowed to carry and self-administer medication. (See MISD School Board Procedure #5139.2 for a specific allowances)

For your convenience, Medication Requests may be faxed to: School Nurse: MIHS Fax # 206-236-3358; IMS Fax # 206-236-3408; West Mercer Fax # 206-230-6043; Lakeridge Fax # 206-230-6232; Island Park Fax # 206-230-6251

Medical Health Care Provider Request

Medication name and strength:	#1	#2
Dosage (# of pills/tsp. etc.):	#1	#2
Time of administration:	#1	#2
Reason for administration:	#1	#2
Side effects:	#1	#2
Known medication allergies:		
Other medications being taken by student:		

As physician for this student, I agree he/she is capable of self-administration and may carry the above meds with him/her:

Yes ☐ **No** ☐

I request and authorize the administration of the above medication(s) for the period beginning _____ day of _____ 20_____ through _____ day of _____ 20_____ as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____

(Medical Health Care Provider Signature) *(Date)*

_____

(Type or Print name of Medical Health Care Provider) *(Phone)* *(Fax)*

Parent/Guardian Request

I certify that I am the parent, legal guardian, or person in legal control of the above-named student. I request and authorize the Mercer Island School District to administer this medication to the above named student in accordance with the instructions of the authorizing student's medical health care provider above. I also authorize the District to enter into a Mutual Exchange of Information with the student's medical health care provider named above. I acknowledge receipt of the district's procedures for medication in the school.

If the medical health care provider, school nurse and principal agree, I also give permission for my child to carry and self-administer this medication at school: Yes ☐ **No** ☐

_____

(Parent/Guardian Signature) *(Date)*

_____

(School Nurse Approval) *(Date)*