CAMAS SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN CAMAS SCHOOL DISTRICT

Student's Name: _____ School Year: _____

DOB: _____ Gr: _____ School: _____ School Fax: (360) 833-5575

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROVIDER (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication: _____

Dosage/Frequency: _____

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

Diagnosis or reason for medication: _____

Possible major side effects of medication and/or side effects to report:_____

Student is capable of self-carrying/administering medication? ☐ Yes ☐ No

BACKUP MEDICATION KEPT IN HEALTH ROOM IS HIGHLY ENCOURAGED!

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

_____	_____	_____
Licensed Provider Signature	Clinic Name	Date
_____	_____	_____
Name (Print or type)	Telephone	Fax

THIS PORTION TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN

I request and authorize the school to administer medication to the above medication to the above identified student in accordance with the health care provider's instructions. I may revoke this authorization by writing to my student's school district. If I did, it would not affect any actions already taken by the school district based on this authorization. Once health care information is disclosed, the person or organization that receives it may re-disclose it in conformance with applicable laws. Confidentiality or information provided to my student's school district is protected by the federal Family Education Rights and Privacy Act.
My signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parent/legal guardian shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student (CSD policy 3416).

You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I also give the Health Care Provider:

Permission to fax this form to the school: ☐ Yes ☐ No
Permission for my student to self-carry and self-administer medication: ☐ Yes ☐ No

_____	_____
Parent/Legal Guardian Signature	Date of Signature

Reviewed by: _____
School Nurse/Date

Please note:

1. All prescribed medication must be provided in a pharmacy labeled container (matching the provider's order) with the name of your student, name of the medication, and the dosage and frequency in which the medication is to be given.
2. Over the counter medications must have an authorization from a health care provider and be in the original container.
3. Medications must be brought to the school by the parent/guardian.
4. No more than a 20 day supply may be kept at school.
5. If your student's medication is needed during a field trip, you must bring a single dose of the medication in a separate container/bottle labeled by a pharmacist. You can request this from your student's pharmacy. Please bring this to school at least 3 days before the scheduled field trip.

PLEASE SEE BACK PAGE FOR INSTRUCTIONS

If your student requires medications at school,
please refer to the following instructions:

1. Notify your school nurse right away. If medication is needed for a life-threatening condition, the nurse may need to work with parent to create a care plan. Direct school numbers can be located on the district website at camas.wednet.edu and are listed below.
2. Please complete parent section of the medication authorization form and provide student details at the top of the form.
3. Send to healthcare provider to complete and sign. If multiple medications needed at school, please fill out one form for **each** medication.
4. You or your provider may fax completed medication authorizations to (360) 833-5575.
5. Return form(s) with medication to school **before the first day of school.** You may want to call the nurse at your school directly to schedule a time to drop off medication.
6. Contact nurse with any further questions or concerns.

SCHOOL CONTACTS

Health Services Fax: (360) 833-5575

Preschools:

Papermaker Preschool: (360) 833-5750

Head Start Preschool: (360) 567-2720

Camas Community Preschool: (360) 833-5547

Woodburn Preschool: (360) 833-5860

Lacamas Lake Preschool: (360) 833-5740

Elementary Schools:

Woodburn Elementary: (360) 833-5860

Lacamas Lake Elementary: (360) 833-5740

Helen Baller Elementary: (360) 833-5720

Dorothy Fox Elementary: (360) 833-5700

Grass Valley Elementary: (360) 833-5710

Prune Hill Elementary: (360) 833-5730

Middle Schools:

Liberty Middle School: (360) 833-5850

Skyridge Middle School: (360) 833-5800

Odyssey Middle School: (360) 833-5780

High Schools:

Hayes Freedom High School: (360) 833-5600

Discovery High School: (360) 833-5780

Camas High School: (360) 833-5750