SPOKANE INTERNATIONAL ACADEMY

SIA HEALTH SERVICES

777 E Magnesium Rd. Spokane, WA 99208 - (509) 209-8730 - Fax (509) 321-9650

MEDICATION REQUEST FORM

Student Name:_____ Birthdate:_____

School:_____ Grade: _____

TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication(s)	Dosage(s)	Reason for Medication(s)	Time(s) of Day To Be Taken

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

Possible side effects of medication: _____

_____

Inhalers: This student has demonstrated, to a licensed health professional in my office, the ability to

correctly administer this medication: ☐ Yes ☐ No

Student may carry inhaler on his/her person: ☐ Yes ☐ No

EpiPens: This student has demonstrated, to a licensed health professional in my office, the ability to

correctly administer this medication: ☐ Yes ☐ No

Student may carry an EpiPen on his/her person: ☐ Yes ☐ No

Note: When a Nurse isn't available for assessment of a student experiencing anaphylaxis, **EpiPen will be the first treatment.**

Non-oral medication: Student is capable of self-administration: ☐ Yes ☐ No

I request/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 which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by school personnel who have no formal medical education.

_____ _____

Date of signature Signature (Licensed Health Professional with Prescriptive Authority)

Phone Number: _____ Name: _____

(Print or Type)

NOTE: This form MUST be signed by a licensed health professional with prescriptive authority.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to be above-identified student in accordance with the doctor's instructions 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. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

Permission to carry inhaler: ☐ Yes ☐ No

Permission to carry EpiPen: ☐ Yes ☐ No

Permission to self-administer non-oral medication: ☐ Yes ☐ No

Date of Signature_____ Parent/Guardian Signature_____

Telephone Number: (Home)_____ (Cell) _____ (Work) _____

Spokane International Academy

PARENT INFORMATION ON MEDICATION AT SCHOOL

Pursuant to Chapter 195, Laws of 1982 and Chapter 28A.210 RCW, Spokane International Academy is authorized to administer oral, topical or nasal medications, and eye drops or ear drops to students during school hours. It is our policy that such medications will only be administered when the failure to receive the medication may result in the student being unable to attend school and/or well enough to participate in learning activities. We define medication to mean all drugs - whether prescription or over the counter. Medication must be brought to the school office by the parent/guardian/custodian and will be stored in a locked cabinet.

THE FOLL0WING CONDITIONS MUST BE MET:

I. Prescription Medication
   1. All medication must have written orders. The medication request must be signed by a licensed health professional who has prescriptive authority.
   2. All medication must have signed parent/guardian/custodian permission.
   3. All medication must be in the original prescription bottle (container) and properly labeled with student's name, name of drug, dosage, name of health professional who is prescribing, and the time of day to be given.
   4. Sample medication must also be properly labeled and in the original container or package.

II. Back-up Medication
   1. It is highly recommended that students who self-carry medication for life threatening health conditions (i.e. Epinephrine and/or inhalers) keep back-up medications in the health room office.

III. Non-Prescription Medication
   1. Non-prescription medication (i.e. cough drops, vitamins, aspirin, cough syrup or any over-the-counter medication) will not be given without written prescriptive orders plus signed parent/guardian/custodian permission.
   2. Non-prescription medicine must be in the original container and must be labeled with the student's name, the prescribing authority, dosage, and time of day to be given.

IV. Non-Oral Medication
   1. School personnel may administer eye drops, ear drops, nasal drops/sprays, ointments, & topical medication.
   2. School personnel (except school nurses) will NOT administer rectal or injectable medication. These medications must be self-administered by the child or the parent/guardian/custodian, or an adult designee may come to school and administer the medication.
      Exception: Injectables in life-threatening situations (i.e. Epinephrine for Anaphylaxis).
   3. If medication is self-administered, it must be indicated on the Medication Request Form.
   4. If medication is ordered, "If a nurse is available…", this does not imply or guarantee a nurse will be on site at all times to give that medication.

V. Administering Medication
   1. The school district form, Medication Request Form, must be completed and signed by a health professional prescribing within the scope of his/her prescriptive authority. This form is available at any school office.
   2. The parent/guardian/custodian must fill out and sign the parent portion of the form.
   3. This authorization is good for the current school year only.