15510 1st Ave NE • PO Box 519 • Duvall, WA 98019 • 425.844.4500 • 425.844.4502 FAX

RIVERVIEW SCHOOL DISTRICT
Building Bridges to the Future

MEDICATION AUTHORIZATION

www.rsd407.org

Medication should be ordered to be given to a student at school ONLY WHEN ABSOLUTELY NECESSARY. Whenever possible, the parent and Licensed Health Care Provider are urged to design a schedule for giving medication outside of school hours. If this is not possible, the medication will be dispensed by designated school personnel. Prescription medication is to be furnished in the original container, labeled with the name of the medication, the amount to be taken, frequency of administration, the name of the physician, and the name of the child. Over the counter medication is to be furnished in the original unopened container with label, directions, and expiration date clearly legible. This authorization is good for the current school year only. Unused medication should be collected from the school. Any uncollected medication will be destroyed at the end of the year or at the end of the prescribed duration of administration, whichever is sooner. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the Licensed Health Care Providers directions.

Student's Name: _____ Birth Date: _____

School: _____ Teacher/Grade: _____

Parent/Guardian Name: _____ Home Phone: _____

Business Phone: _____ Other Phone: _____

Parent/Guardian Signature: _____ Date: _____

ONE MEDICATION PER SHEET PLEASE

This section to be completed by the Licensed Health Care Provider

Medication to be administered: _____

Dosage and mode of administration: _____

Time to be administered: _____

Purpose of medication: _____

Possible side effects of medication: _____

Dates for administering medication: _____Current School Year _____Other: _____

Special storage requirements: _____None _____Refrigerate _____Other: _____

Student may self-administer: __Yes __ No Student self-carries medication: ____ Yes ____ No

Student has demonstrated safe and appropriate self-administration: _____Date _____
Signature

Licensed Health Care Provider: (Please print): _____ Date: _____

Address: _____ Phone: _____

Signature: _____ Fax: _____

School Nurse Review: Date Received: _____ Date Received: _____

Expiration: _____ Signature: _____

Notes: