Health Services Department
134 Marion Avenue N
Bremerton, WA 98312-3542
Office: 360-473-1073 Fax: 360-473-1043

Medication Authorization Form

The section below must be completed by the PARENT / GUARDIAN

School:_____ Fax: _____

Student's Name:_____ DOB:_____ Grade:_____

Medication(s) requested:_____

Health Care Provider:_____ Phone & Fax:_____

Please check ONE box and sign below:

☐ I request that the authorized persons at school assist my child in taking medication(s) described below. I also give my permission for the exchange of information between the school nurse and Health Care Provider.

☐ I request that my child be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and Health Care Provider. I shall hold harmless and indemnify the school and Bremerton School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by the above named child.

☐ I am 18 years old and signing this form on my own behalf *(RCW 26.28.015 or RCW 70.02.30)*. I also give permission for exchange of information between the school nurse and Health Care Provider. I shall hold harmless and indemnify the school and Bremerton School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by the above named child.

I understand that this authorization is good for the current school year only. The medication will be furnished in the original container labeled by the pharmacy or health care provider with the student's name, name of the medication, the amount to be taken, and the time of day to be taken. I will keep track of the expiration dates for the medication. ***If medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed*.**

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ Date: _____

The section below must be completed by the HEALTH CARE PROVIDER *(MD, DO, ND, DMD, DC, PA, ARNP, or CNM)*

	Medication #1	Medication #2
Medication:		
Dose:		
Route:		
Time to Administer Medication:		
Diagnosis for which medication is given:		
Is student capable to carry and safely administer without supervision:	☐ Yes* – Student can self-carry and administer ☐ No – May not self-carry / administer	☐ Yes* – Student can self-carry and administer ☐ No – May not self-carry / administer
Authorization for:	☐ School year:_____ ☐ Other dates:_____	☐ School year:_____ ☐ Other dates:_____

I request that the named student be administered the medication(s) listed in accordance with the instructions indicated, as there exists a valid health reason which makes administration advisable during school hours.

Health Care Provider's Name:_____ Phone:_____

Health Care Provider's Signature:_____ Date:_____

* Checking "Yes" indicates that student has been instructed in the purpose and appropriate method/frequency of use