Bremerton School District 100-C
Health Services Department
134 Marion Avenue North
Bremerton, WA 98312-3542
Office: 360-473-1073 Fax: 360-473-1043

Medication Authorization Form

For all prescription and over-the-counter medications administered at school
This document is in effect for the current school year and must be renewed annually

School:_____ Year:_____ School Fax #:_____

This section must be completed by the PARENT / GUARDIAN

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

I request/authorize the school to administer the identified medication(s) to the above student. I understand that:

- I will furnish medication(s) in original container and pick it up on the last day of school
- I will monitor the expiration date of medication(s)

☐ I give my permission for exchange of information between the School Nurse and Health Care Provider

_____ **Date:** _____
Parent / Guardian / Student Signature

Medication(s) requested:_____

Health Care Provider:_____ **Phone:**_____

Please check one box:

☐ I request that the authorized persons at school assist my child in taking medication(s) described below

☐ I request that my child be allowed to self-administer medication. 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 signing this form on my own behalf *(RCW 26.28.015 or RCW 70.02.30)*

This section is to be completed by the HEALTH CARE PROVIDER: *(MD, DO, ND, DMD, DC, PA, ARNP, or CNM)*

	Medication #1	**Medication #2**
Medication:		
Dose:		
Tablet / Capsule / Inhaler / Injection / Other:		
Time to Administer Medication:		
Diagnosis for which medication is given:		
Please check if student is or is not capable to carry and administer without supervision:	☐ Yes* – Student can self-carry/administer ☐ No – May not self-carry / administer	☐ Yes* – Student can self-carry/administer ☐ No – May not self-carry / administer

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

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.

Medications are authorized for the school year:_____

Health Care Provider's Name:_____

Health Care Provider's Signature:_____ **Date:**_____