Issaquah School District #411

Disaster Planning Authorization for the Administration of Medication for 72 hours at School

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TO: Parent/Legal Guardian, Licensed Health Care Provider

RE: Disaster Planning: Administration of Medication for 72 hours at School

In the event of a major disaster such as a severe earthquake, schools may be responsible for the care of their students for as much as 72 consecutive hours. With this in mind, it is important to consider those students who require daily medication for their health and well being.

The administration of any oral medication to a student by a district employee must be requested and authorized in writing by either a parent or legal guardian **and** a licensed health care provider acting within the scope of his/her license. Specific instructions for administration must be included.

All medication provided by parents must be in the original container.

The label must include:
1. the student's name
2. name of medication
3. daily dosage
4. mode of administration
5. name of the licensed health care provider

Requests for administration of medication during a disaster are valid for **one academic year only.**

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Student Name:____Birth Date:____________________

School: ____Grade: ____________________

I give my permission for exchange of information between the school district staff and the licensed health care provider.
Date: _________Parent/Guardian Signature: ____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER

Name of Medication Dosage Time of Day To Be Taken

____

Diagnosis or reason for medication: ____

For inhalers student is capable self-administration: YES ☐ NO ☐

Possible side effects of medication: ____

Additional Instructions:____

____

I request/authorize the school to administer the above medication to the above identified student in accordance with the instructions indicated above for the period from __________ to __________ (not to exceed current school year).

Licensed Health Care Provider Signature: _______________________________Date: ____________

Telephone Number: _____________________________ Fax Number: _________________________

Print Name: ____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Name of Medication Dosage Time of Day To Be Taken

____

Diagnosis or reason for medication:____

I request/authorize the school to administer the above medication to the above identified student in accordance with the Licensed Health Care Provider's instructions for the period from ______________ to __________ (not to exceed current school year).

Parent/Guardian Signature: __________________________________Date: ______________________

Telephone Number: (Home) ____________________(Work) _______________(Cell) _____________

School Nurse approval: ____ Date: ____________