academy for precision learning®

Redefining Potential | Inclusion with Results

Authorization for Medication to be Taken at School

The following section is to be completed by the PARENT/GUARDIAN (please print).

_____ _____

(Student name as it appears on prescription) (Today's date)

_____ _____

(Student gender) (Student birthdate)

_____ _____

(Health Care Provider's name) (Health Care Provider's phone number)

_____

(Health Care Provider's Address)

The following section is to be completed by the HEALTHCARE PROVIDER (please print).

If more than one prescription medication is required, a HEALTHCARE PROVIDER must provide the following information for each medication taken at school

I have determined that the medication named below is advisable during the school day.

Diagnosis for which medication is given: _____

Name of medication: _____ Dose: _____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other: _____

If medication is to be given DAILY, at what time? _____

If medication is to be given WHEN NEEDED, describe indications

_____

How soon can it be repeated? _____

Is the child authorized to medicate himself/herself? ☐ Yes ☐ No

(If yes, must sign Agreement of Exemption on reverse side of this form)

Length of time this treatment is recommended: _____

Possible side effects: _____

Emergency procedure in case of side effects:

_____

Date: _____ Health Care Provider's Signature: _____

AGREEMENT OF EXEMPTION

Please check only one box:

☐ I request that authorized persons at school assist my child in taking the medicine(s) described below. I also give my permission for exchange of information between the school district staff and the health care provider.

☐ I request that my child be allowed to self-administer medication (age 12 or older). I also give my permission for exchange of information between the school district staff and the health care provider.

If you choose to allow your child to self-administer prescription or OTC medication, please call/email your student's head teacher and the administration of the medication and proper dosage instructions.

☐ Student has been trained by health care provider and is safe to self-administer medication.

The parents/guardians shall hold harmless and indemnify the Academy for Precision Learning and its officers, employees and agents against all claims, judgments, or liabilities arising out of the selfadministration and carrying of medication by their child.

_____	_____	_____	_____
(Parent/Guardian)	(Date)	(Parent/Guardian)	(Date)
_____	_____	_____	_____
(School Director)	(Date)	(Health Care Provider)	(Date)

Washington State Law requires that prescription medications left at school must have the following:

- Signed Authorization for Medication to be Taken at School
- Student's name
- Medication in original container
- Name and strength of medication
- Time and method of administration
- Length of time/days to be given

APL Staff members are trained in the administration of Epi-pens in case of an emergency. An epi-pen will be kept in the classroom.

Hospital of Preference:

APL will do it's best to accommodate family preferences, should a child require urgent care. However, medical emergencies may necessitate seeking care elsewhere. **Please circle your hospital of preference below.**

Children's Hospital	**UW Medical Center**	**Other (please specify):**
		_____
4800 Sandpoint Way NE	1959 N.E. Pacific	_____
Seattle WA, 98115	Seattle, WA 98195	_____
206-987-2000	206-598-3300	_____