School: _____
Return Fax #: _____
Attn School Nurse: _____

School Medication Orders

For (Student Name): _____ Date of Birth: _____

The following section is to be completed by the LICENSED HEALTH CARE PROVIDER:

Medication Name: _____

Reason for which medication prescribed: _____

_____

Medication Order **Duration:** ❑ Entire current school year **OR** ❑ Start _____ & End _____

Medication Administration Guidelines:

Dosage:_____ **Strength:** _____

Form: ❑ Tablet / capsule ❑ Liquid ❑ Inhaled ❑ Nebulized ❑ Injection ❑ Other _____

Frequency:

❑ Scheduled times to be given: _____
❑ PRN/When needed. Describe indications and frequency: _____
_____

Restrictions and/or significant side effects? _____

If prescribing an asthma inhaler or epinephrine injection, may the student carry the medication?

❑ No or Not Applicable
❑ Yes & I have instructed this student on purpose, appropriate method, frequency of use & student demonstrates necessary skill to use the medication including any device necessary for administration.

Any special requirements for medication storage? _____

Licensed Health Care Provider Signature: _____ Date:_____

Printed HCP name: _____ Phone:_____

Address: _____ Fax: _____

The following section is to be completed by the PARENT/ GUARDIAN

I request that the principal, or a staff member designated by her/him, be permitted to dispense the licensed health care provider authorized medication as described. I also give my permission for the exchange of information between the school district staff and the health care provider listed. I understand that the medication is to be furnished by me in its original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of health care provider. I understand that my signature below indicates my understanding that the school accepts no liability for reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only. If my child's physician or authorized prescriber authorizes the student to medicate himself/herself at school, I, the parents/guardian, shall hold harmless and indemnify the school and Snoqualmie Valley 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 student. If necessary, the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed by the school nurse. I am the parent or legal guardian of the child named. According to state law no distinction will be made between prescription and over the counter medication. Therefore, this form must be signed by parent/guardian AND physician for over-the-counter and prescription medicines.

Parent/Guardian Signature: _____ Date:_____ Phone: _____

School: _____
Return Fax #: _____
Attn School Nurse: _____

Parent/Guardian Instructions for Student Medications at School

In accordance with the SVSD Medication Policy and Washington State Law, the following requirements must be met for a student to receive any medication (prescription or over-the-counter) at school:

Required Documentation:

1. **COMPLETE School Medication Order** – A completed School Medication Order form signed by both a licensed healthcare provider and the parent/guardian. This form must be updated each school year.
2. **COMPLIANT Medication I** – Must be in its original container, match the order request, and be non-expired.

Additional Requirements:

- A current, completed written request from a licensed healthcare provider (within their prescriptive authority) and parent permission is needed before any medication can be at school.
- Students are not permitted to carry medication without this specific authorization. Violations of this policy could lead to disciplinary action.
- Washington State law (RCW 28A.210.260 & 270) requires both prescription and over-the-counter medications to have a signed medication order from a licensed healthcare provider.

Emergency Medications:

- Students with emergency medications for life-threatening conditions (e.g., allergies, asthma, seizures) must have submitted complete school medication orders and compliant medication before the first day of school as a condition of attendance.
- If emergency medications are no longer necessary, a signed letter from the healthcare provider is required for discontinuation.

Self-Carry Conditions:

- If the healthcare provider & parent request self-carry permission, the school team will consider the student's age, maturity, and ability to handle the medication, as well as the nature of the medication & the circumstances under which it will be administered.
- Self-carry permission is generally not granted for controlled substances or non-emergency medications at elementary levels.
- If granted, the student may only carry enough medication for a single school day or a field trip,& must not share it with others.
- For emergency medications, the student and guardian are responsible for ensuring the medication is unexpired and with the student at all times. The parent/guardian must ensure the student understands these conditions.
- Violating any self-carry conditions may result in termination of the permission and possible disciplinary action.

If you have any questions or concerns regarding medication at school, please contact your school nurse.

Building Nurse Name and Contact