RAINIER CHRISTIAN SCHOOLS

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AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

STUDENT NAME_____DOB_____

SCHOOL_____GRADE/TEACHER_____

PARENT AUTHORIZATION FOR OTC OR MEDICATION FOR LESS THAN 15 DAYS

Name of Medication_____ Dosage_____

Time of day to be taken_____

Reason for medication to be given during school hours_____

Date of first dosage_____ Date of last dosage_____

I certify that I am the parent/legal guardian of the identified student and request and authorize the school to administer the identified medication as stated (not to exceed one year for OTC medication). Medication supplied in original container **ONLY** is accepted. Such medication may be administered by untrained school personnel.

PARENT NAME (printed)_____

SIGNATURE_____DATE_____

PHYSICIAN'S ORDERS FOR MEDICATION

This order is required for prescription medication or for OTC medication administered for 15 days or longer (RCW 28A.210.260).

Rx

I request and authorize the above named student to be administered the above identified medication in accordance with the instructions indicated for the period stated. I assert that a valid health reason exists which makes the administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by untrained school personnel.

Signature_____
Date_____
Name (printed)_____
Telephone_____