RIVERSIDE CHRISTIAN SCHOOL

Rooted in Christ. Ready for Tomorrow.

Authorization and Release

For Administering Medicine to Student at School or School-Sponsored Activity

A separate written Authorization and Release must be submitted each school year for each medicine to be administered to a student, and for each change in the dosage, time(s) and/or route of administration.

Student Name:_____Date of Birth: _____Grade:_____ School Year: _____

Health Care Provider Authorization and Directions - Physician/Dentist must complete and sign this section

Name of Medicine:_____

The Medicine is: ❒ Prescription ❒ Nonprescription

Purpose of Medicine:_____

Dosage:_____ Route of Administration:_____

Time(s) the Medicine is to be Administered:_____

Starting Date: _____ Ending Date:_____

(All Authorizations expire at the end of the school year)

Possible Side Effects of Medication:_____

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication such as inhalers and EpiPens® **must** be authorized by the prescriber.
Prescriber's authorization for self-carry/self-administration of emergency medication:

I authorize this student to self-carry/self-administer the above medication ❒ Yes ❒ No

Signature of Provider: _____Date:_____

Printed Name of Health Care Provider: _____Office Phone:_____

Special Instructions

Prescription Medication: Must be furnished in the original pharmacy labeled container. The student's name, name of the medicine, dosage, name of prescribing health care provider (who is required to furnish Health Care Provider Authorization and Directions above), date prescription was filled, and expiration date must be printed on the medicine container's pharmacy label.

Nonprescription Medication: Must be furnished in the original container labeled by the pharmaceutical company or other commercial distributor of the medicine.

Parent/Guardian Request, Permission and Release

I hereby request and give my permission for Riverside Christian School to administer to my child the medicine named in the above Health Care Provider Authorization and Directions, as specified by the health care provider. In connection with my request, I hereby authorize the health care provider to provide information to School personnel who may be involved in administering the medicine to my child. I hereby release and hold harmless the School and its board members, employees, and agents from any and all liability, claims, causes of action, damages and demands of any kind whatsoever (except willful and wanton acts or omissions) that may be brought by my child or on my child's behalf for any and all damages, including personal injury to my child, arising out of or in connection with the administering of medicine to my child as provided above.

Signature of Parent/Guardian:_____ Date:_____

FOR STUDENTS WITH ASTHMA OR ANAPHYLAXIS: The PCP must submit "A written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by student during school hours." RCW 28A.210.370