JOHN E. DUNNE
RIVERVIEW PLAZA
16040 CHRISTENSEN RD., SUITE 217
TUKWILA, WA 98188
BUS: (206) 243-7383 FAX: (206) 241-7346

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student's Name _____ Birthdate _____

School _____ Grade _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN

NAME OF MEDICATION(S)	DOSAGE	METHOD OF ADMINISTRATION	TIME OF DAY TO BE TAKEN

Reason for medication to be given during school hours _____

Anticipated effects _____

Possible side effects of medication(s) _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from _____ through _____ as there exists a ***valid health reason which makes 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 medically untrained school personnel.

_____ _____

Date of Signature John E. Dunne

Telephone Number (206) 243-7383

THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or doctors instructions for the period beginning _____ through _____ (not to exceed one school year).

Medication will be supplied to the school in the original container.

_____ _____

Date of Signature Signature

Telephone Number _____ / _____

Home Work

White copy: School Yellow copy: Physician