Bellevue Children's Academy
Authorization for Medication Administration at School
2023-2024

Please note: **ALL** medication administered at school (including over-the-counter) require authorization from a Licensed Healthcare Provider with prescriptive authority (MD, DO, ND, DMD, DC, PA, ARNP, or CNM). For emergency medications such as epinephrine or albuterol, which require an Emergency Care Plan, this requirement can be met by the medication order section of their ECP. Please review our Medication Policies before submitting any medications.

PARENT/GUARDIAN REQUEST

Student's Name: _____ Date of Birth: _____

Grade: _____ Homeroom Teacher or Section: _____

I understand and acknowledge that:

- All medications I provide must be unexpired and properly labeled in their original box.
- My signature gives permission for exchange of information between the School Nurse, pertinent school staff, and the Healthcare Provider regarding this medication order.
- Students may not carry medication unless certain criteria have been met under the Medication Policy.

Please check only ONE box and then sign below:

❑ I request and authorize Bellevue Children's Academy/Willows Preparatory School to **assist my child** in taking the medication in accordance with the LHP's instructions below or attached.

❑ **For WPS only** *(optional – please read carefully)*. I request that my child be allowed to **self-carry and self-administer** the medication in accordance with the LHP's instructions below or attached. My student and I understand the responsibility of self-carrying medication at school and recognize the school will not track compliance, expiration, or amount. I agree to hold harmless and indemnify the school and its officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my student. *I also understand that this requires permission from the school nurse and administrator, who have the final determination.*

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone number: _____

LICENSED HEALTHCARE PROVIDER (LHP) REQUEST

Medication Name: _____ Dosage: _____ Method/Route of administration: _____

TIME(S) for scheduled medications or INDICATIONS/SYMPTOMS for as-needed medications (be specific):

_____

Is student capable of safely self-carrying medication? ☐ Yes ☐ No

Is student capable of safely self-administering medication? ☐ Yes ☐ No

Possible side effects of medication and special instructions, if any: _____

I have determined that the medication named below is advisable during the school day, for the period of:
☐ Duration of current school year (includes summer school) ☐ Other dates: _____ to _____

LHP Signature: _____ Date: _____

LHP Name: _____ Office Phone: _____