Community Colleges of Spokane

Spokane County Head Start/EHS
MEDICATION REQUEST FORM

Child Name: _____ Birthdate: _____

Site/Classroom #: _____ Licensed Physician: _____
(Signature)

DO NOT use this form for children needing emergency medications for Asthma or Severe Allergy/Anaphylaxis at school. An Asthma or Severe Allergy Plan, which includes medication orders, is required. (RCW 28.A 210 & 370)

THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication*	Dosage	Method of administration	Time(s) of day to be given

***One medication per request form**

Reason for medication: _____

For As Needed medications, specify the minimum length of time between doses: _____

Possible side effects and action needed if noted at school: _____

I request/authorize the above named child be administered the above named medication in accordance with the instructions indicated above from (date) _____ to (date) _____ or the entire school year including summer months (if applicable), as there exists a valid health reason which makes administration of medication advisable during school hours. **Medication orders are valid for the current school year only.**

Date of Signature: _____ Licensed Health Professional's Signature: _____

Phone#: _____ Fax: _____ LHP's Name (print): _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Please read Parent Information on the reverse side of this form.

I have read and understand the parent information regarding medication at HS/EHS (reverse side or office) and request/authorize trained HS/EHS staff to administer medication to my child in accordance with the LHP's instructions above for the dates of _____ to _____ or one entire school year including summer months (if applicable). Medication orders are valid for the current school year only.

I understand that a medication dosage could be delayed or missed due to unexpected circumstances or changes in the child's schedule.

I also give my permission for the exchange of information between HS/EHS nurse consultant, HS/EHS Health Specialist, and Licensed Health Professional for the purpose of clarifying medication orders/concerns that could affect safe administration in class.

Date of Signature: _____ **Parent/Guardian Signature** _____

Home Phone: _____ Work/Cell Phone: _____ Alternate Phone: _____

Record Maintenance Statement: This record must be maintained by Head Start for three (3) years.