Bethel SCHOOLS

Dear Parents,

A law has been enacted in Washington that requires children with life-threatening conditions to have a medication or treatment order on file prior to attending school. This law, called Substitute House Bill 2834, took effect on June 13, 2002.

The medication or treatment order must address the life-threatening condition and it must be on file with the school prior to the child attending school. Under the law, "life-threatening condition" means a health condition that will put the child in danger of death during the school day if a medication or treatment order is not in place. In addition, our school nurses will be responsible for putting a nursing care plan in place. The law provides that a child may not attend school in the absence of a medication or treatment order if the child has a life-threatening condition that might require medical services to be provided at school.

Having reviewed the information you provided regarding your child's health, it appears that your child has a life-threatening condition that requires a medication or treatment order.

Please have your health care provider complete the **Physician's Orders For Medication at School** and sign the **Parent Permission**. Return this form to your child's school nurse as soon as possible. Upon receipt of the information from your health care provider, the school nurse will contact you to develop an appropriate nursing plan.

Sincerely,

School Nurse

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Diagnosis: _____

Name of Medication	**Dosage**	**Methods of Administration**	**Time of Day to be Taken**

If given PRN, specify the length of time between doses.

Inhalers: _____
Indicate if Student Must Carry on His/Her Person

Student is capable to self-administer medication: ☐ Yes ☐ No

Possible side effect of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____ to _____ (do not exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Physician/Dentist Signature Date

_____ _____
Physician/Dentist (Print or Type) Telephone Number

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to Carry Inhaler: ☐ Yes ☐No
Permission to self-administer medication: ☐ Yes ☐No

_____ _____
Parent/Guardian Signature Date

_____ _____
Home Telephone Number Work Telephone Number