# Deer Park School District #414

**P.O. Box 190, Deer Park, WA 99006**

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| Deer Park Elementary School | Phone: 464-5600 | Fax: 464-5610 |
| Arcadia Elementary School | Phone: 464-5700 | Fax: 464-5710 |
| Deer Park Middle School | Phone: 464-5800 | Fax: 464-5810 |
| Deer Park High School | Phone: 468-3500 | Fax: 468-3510 |
| Homelink | Phone: 468-3350 | Fax: 468-3360 |

## MEDICATION REQUEST FORM

**Parent/Guardian** please note:

- This form must be completed and signed by the parent/guardian and the Licensed Health Care Professional.
- This form is for both prescription and non-prescription medications.
- **Complete a separate form for each medication.**
- All medication must be transported to and from school by responsible adult.

### Parent/Guardian: Please complete this section (ALL INFORMATION REQUIRED)

Student's Name:____________________ Date of Birth:___________________ Teacher:_______________ Grade:______

I certify that I am the parent, legal guardian or other person in legal control of the above student and request and authorize the school to dispense medication to the above student in accordance with the prescription or doctor's instructions for the period commencing with the _____ day of _____________, 20_____, through the _____ day of __________, 20_____.

In the event of half day school schedule, I want my child to take his/her medication at school ____ Yes ____ No

Parent/Guardian Signature:__________________________________ Date:___________________

Home Phone:__________________ Cell Phone:___________________ Work Phone:__________________

### LICENSED HEALTH CARE PROFESSIONAL: PLEASE COMPLETE THIS SECTION (ALL INFORMATION REQUIRED)

**Medication (name, dosage):**__________________________________________________________________________

**Administration schedule (amount, frequency and route):**_________________________________________________

**Reason for medication:**_____________________________________________________________________________

*Please note: School staff can administer epinephrine by Epi-Pen auto-injector **only.**

**Further Instructions (possible reactions, etc.)** ***This section must be completed if medication is to be dispensed for more than 15 days:***_____________________________________________________________________

I request and authorize that the above named student to be administered the above identified oral medication in accordance with the instructions indicated for the period commencing with the ______ day of _______________, 20_____, through the _______ day of _____________, 20_____, as there is a valid health reason which makes administration of the medication advisable during school hours of during such time that the student is under the supervision of school officials.

**Licensed Health Care Professional Signature:**_____________________________________ **Date:**____________________

Licensed Health Care Professional Name, **Please Print:**__________________________ **Phone:**____________ **Fax:**_____________