For 2006-07 school year
[expires at the end of August]

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Meridian Park School **Shoreline School District** **17077 Meridian Avenue North** **Shoreline, WA 98133**	**ATTENTION: Donna Allred, RN** **FAX: 206.361-4259** **PHONE: 206.368-4124**

Student _____ Birth date _____ Grade _____ Age _____

Parent _____ Address _____ Phone _____

Licensed health professional _____ Phone _____ Fax _____

This section to be completed by PARENT or GUARDIAN:

I request that the school nurse, or designated staff member, administer the medication(s) described below as directed by the above licensed health professional. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions.

I give my consent for the confidential information contained on this form to be FAXed to the above named school.

_____ _____

Parent/Guardian signature **Date**

This section to be completed by LICENSED HEALTH PROFESSIONAL:

MEDICATION	DOSAGE	ROUTE	TIME TO BE GIVEN

Health condition requiring administration of medication _____

Possible side effects: _____

Other instructions: _____

I request and authorize that the above-named student be administered the above-identified medication as per the instructions indicated above from [dates] 9/1/06 to 8/31/07 [not to exceed current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____ _____

Signature of Licensed Health Professional **Name [PRINT OR TYPE]** **Date**

Rev 5/7/03:kj