Bellevue Children's Academy & Willows Preparatory School

Authorization for Administration of Medication at School

2021-2022

I hereby authorize Bellevue Children's Academy/Willows Preparatory School staff to administer medication to the below-named student in accordance with the instructions below, for the authorized period of ___________________ (Month & Year) to _________________ (Month & Year) (not to exceed the current school year, June 2022).

Student's Name: ____ Date of Birth: _______________

Grade: ________________________ Homeroom Teacher: ______________________________________

Name of Medication	Dosage	Expiration Date	Method to Administer	When to Administer (cannot be "as needed")

Diagnosis or reason for taking the above-named medication: ______________________________________

Is student is capable of self-administration of medication? ☐ Yes ☐ No

Are there special storage requirements? ☐ Yes ☐ No If yes, please specify: _________________________

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

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Emergency procedure to be followed in case of serious side effects:_________________________________

I understand that Bellevue Children's Academy/Willows Preparatory School (BCA/WPS) will administer medication (either prescribed or over-the-counter) to my student *only* if said medication is accompanied by a separate signed physician's note* indicating 1) the name of the student, 2) name of the medication, 3) dosage, 4) frequency of administration, and 5) time frame for medication.

I understand that it is my responsibility to administer medication to my child, and that I will not hold BCA/WPS responsible for failing to administer medication, or for administering it improperly.

I understand that BCA/WPS staff cannot administer expired medication to my student and it is my responsibility to provide non-expired medication to the school when necessary.

I understand that students may not carry medication on their persons or store medication at BCA/WPS in lockers, cubbies, backpacks, etc. All medications (either prescribed *or* over-the- counter) must be kept at the front office or with the school nurse.

Signature: ____ Date: ________________________

Parent or Legal Guardian

Phone number: (_____)__________________

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***Health Care Provider Consent**

A parent/guardian may provide the sole consent for a medication, (*without the consent of a health care provider*), if and only if the medication meets all of the following criteria:

a. The medication is over-the-counter and is one of the following:

- Antihistamine
- Non-aspirin fever reducer/pain reliever
- Non-narcotic cough suppressant
- Decongestant
- Ointment or lotion intended specifically to relieve itching or dry skin
- Diaper ointment or non-talc powder intended for use in diaper area (valid up to 6 months)
- Sunscreen for children over 6 months of age (valid up to 6 months)
- Hand sanitizers for children over 12 months of age and

b. The medication has instructions and dosage recommendations for the child's age and weight; and
c. The medication duration, dosage, amount, and frequency specified on consent form is consistent with label directions and does not exceed label recommendations.

The written consent of a health care provider with prescriptive authority is required for prescription medications and all over-the-counter medications that do not meet the above criteria (including vitamins, iron, supplements, oral re-hydration solutions, fluoride, herbal remedies, and teething gels and tablets).