Two Schools One Philosophy

Bellevue Children's Academy & Willows Preparatory School

Authorization for Medication Administration at School

2022-2023

Please note: This form must be completed and signed by both the parent/guardian **and** the student's Licensed Healthcare Provider (LHP), with prescriptive authority. This form is for both **prescription** and **nonprescription** medication. Complete a separate form for each medication. All medication must be transported to and from the school by a responsible adult.

PARENT/GUARDIAN REQUEST

Student's Name: _____ Date of Birth: _____

Grade: _____ Homeroom Teacher or Section: _____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize Bellevue Children's Academy/Willows Preparatory School to administer medication to the above identified student in accordance with the prescription or LHP's instructions for the period commencing: START DATE _____ TERMINATION DATE _____ or END OF SCHOOL YEAR (including summer school: Yes___ No___).

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 all medications I provide must be in their original box with all necessary supplies (dosage cup, etc.) and be unexpired. 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 needed.

I understand that students may not carry medication on their persons or store medication at BCA/WPS in lockers, cubbies, backpacks, etc. unless certain criteria have been met under the school medication policy.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone number: _____

LICENSED HEALTHCARE PROVIDER (LHP) REQUEST

Medication Name: _____ Strength & Dosage: _____ Method of administration: _____

Administration schedule/frequency of administration: _____

Reason for Medication (and signs & symptoms for which medication should be administered, if applicable):

_____

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

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

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

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing: START DATE _____ TERMINATION DATE _____ or END OF SCHOOL YEAR (including summer school: Yes___ No___), as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

LHP Signature: _____ Date: _____

LHP Name: _____ Office Phone: _____