



## Bellevue Children's Academy & Willows Preparatory School Authorization for Medication Administration at School 2023-2024

Please note: **ALL** medication administered at school (including over-the-counter) require authorization from a Licensed Healthcare Provider with prescriptive authority (MD, DO, ND, DMD, DC, PA, ARNP, or CNM). For emergency medications such as [epinephrine](#) or [albuterol](#), which require an [Emergency Care Plan](#), this requirement can be met by the medication order section of their ECP. Please review our [Medication Policies](#) before submitting any medications.

### PARENT/GUARDIAN REQUEST

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Grade: \_\_\_\_\_ Homeroom Teacher or Section: \_\_\_\_\_

I understand and acknowledge that:

- All medications I provide must be unexpired and properly labeled in their original box.
- My signature gives permission for exchange of information between the School Nurse, pertinent school staff, and the Healthcare Provider regarding this medication order.
- Students may not carry medication unless certain criteria have been met under the Medication Policy.

Please check only ONE box and then sign below:

- I request and authorize Bellevue Children's Academy/Willows Preparatory School to **assist my child** in taking the medication in accordance with the LHP's instructions below or attached.
- For WPS only (optional – please read carefully).** I request that my child be allowed to **self-carry and self-administer** the medication in accordance with the LHP's instructions below or attached. My student and I understand the responsibility of self-carrying medication at school and recognize the school will not track compliance, expiration, or amount. I agree to hold harmless and indemnify the school and its officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my student. *I also understand that this requires permission from the school nurse and administrator, who have the final determination.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

### LICENSED HEALTHCARE PROVIDER (LHP) REQUEST

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Method/Route of administration: \_\_\_\_\_  
TIME(S) for scheduled medications or INDICATIONS/SYMPTOMS for as-needed medications (be specific):  
\_\_\_\_\_

Is student capable of safely self-carrying medication?  Yes  No

Is student capable of safely self-administering medication?  Yes  No

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

I have determined that the medication named below is advisable during the school day, for the period of:

Duration of current school year (includes summer school)  Other dates: \_\_\_\_\_ to \_\_\_\_\_

LHP Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
LHP Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_