MEDICATION AUTHORIZATION ORDER FORM

Heritage Christian Academy
19527 104th Ave. N.E. Bothell, WA 98011
Phone (425) 485-2585 Fax (425)-800-0679

Student Name: **M or F**

Birthdate: **Grade/Teacher:**

School Guidelines for Medications

If a student must receive prescribed or non-prescribed oral medications during school hours, the following procedures must be followed. Prescribed or non-prescribed (OTC) medication may be dispensed to students on a scheduled basis once a completed Medication Authorization Order Form, signed by a LHP (licensed health care provider) and parent/guardian is on file. The request is valid for the current academic school year, unless a shorter time period is specified. The medication, supplied by the parent/guardian must be in the original, properly labeled container, including any over the counter medication and samples. Heritage Christian Academy accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the LHP order.

MEDICATION ORDER (to be completed by LHP)

Diagnosis	Medication	Dosage	Route	Time/Interval/ Condition/Symptom	Self-carry	Side Effects
					Yes / No	
					Yes / No	
					Yes / No	
					Yes / No	
					Yes / No	

LHP INFORMATION/SIGNATURE

I request and authorize that the above-named student receive the above-identified medication(s) in accordance with the instructions indicated, beginning with the day_____of_____, 20___ (not to exceed the current school year). There exists a valid health reason, which makes administration of the medication advisable during school hours.

LHP Signature: Date:

LHP Name: Phone: Fax:

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

- Due to unforeseen circumstances, I understand a dose may be delayed or missed.
- All prescription and over-the-counter medication must be in their original, labeled container with student's name and instructions matching the Medication Authorization Order Form.
- When notified by school personnel that medication remains after the course of treatment I will collect the medication from the school or understand that it will be destroyed.
- Heritage Christian Academy assumes no responsibility for self-carried medications.
- My signature below indicates that I have read and understand and will abide by the school's medication policy.
- ***Please indicate if you want medication given on half days _____YES _____NO

Parent/Guardian Name and Signature: Date:

Phone number (s):

Student Signature: Date:
(only if authorized to self-carry)