CASCADE CHRISTIAN SCHOOLS

Medication Authorization Form
School Year: _____

- ❑ **Junior High**
- ❑ **High School**
- ❑ **McAlder Early Learning Center/Elementary/Recreation**
- ❑ **Puyallup Early Learning Center**
- ❑ **Puyallup Elementary/Recreation**
- ❑ **Frederickson Early Learning Center/Elementary/Recreation**

Child's name:	Date of birth/age:
Name of medication:	Reason for medication:
Start date:	Stop date:
We administer medications at: ❑ 12 p.m. ❑ 2 p.m. Other time(s) ordered by licensed health practitioner: _____	Dosage:
Possible side effects:	❑Oral ❑Topical ❑Ear ❑Eye ❑Other _____ How to give (route)? _____ _____
Above information consistent with label? ❑Yes ❑No Confirmed by: _____	Requires refrigeration? ❑Yes ❑No
Has an Individual Health Plan (IHP) been developed? ❑Yes ❑No	Person processing form:
Special instructions:	

❑ I have attached the required doctor's action plan.
❑ I am providing at least three full days' dosage in the event of an emergency.
I authorize _____ to give the above medication.
(Name of Campus)

_____ Date: _____ Daytime phone: _____
Parent or Guardian Signature Email: _____

_____ Date: _____ Daytime phone: _____
Prescribing Licensed Health Practitioner Signature* Email: _____

EARLY LEARNING: Medications listed below, with clear instructions for your child's age written on the label, may be administered with only a parent/guardian authorization. All other medications require additional authorization from a prescribing licensed health practitioner.

- Antihistamines (Benadryl, Sudafed, etc.)
- Non-aspirin pain relievers and fever reducers (Tylenol, Motrin, etc.)
- Non-narcotic cough suppressants
- Decongestants
- Anti-itching ointments or lotions, intended specifically to relieve itching
- Diaper-area ointment and non-talc powders, intended specifically for use in the diaper area of the child
- Sunscreen

* A prescribing licensed health practitioner's signature *is required* if the label does not provide clear instructions or the parent/guardian instructions differ from the label (i.e., many medications for children under 2 years of age).

KINDERGARTEN-GRADE 12: In order to align with the State Office of Superintendent of Public Instruction's interpretation of the statute regarding over-the-counter medications and school compliance (RCW 28A.210.260 [4] AND RCW 28A.210.270), we must request both parent/guardian ***and*** *licensed health practitioner signatures for both prescription ***and*** over-the-counter medications.

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Medication Record

(Must be filled out by the person[s] giving the medication)

Child's name: _____ **Name of medication:** _____

SCHOOL STAFF: Place this form in the child's individual file when course of medication is completed.

Date	Time	Dosage	Initials		Reason NOT Given	Side Effects Observed

Signatures that correspond to initials of persons giving medication:

Printed Name: _____ _____ **(Signature)** ____ **(Initials)**

Printed Name: _____ _____ **(Signature)** ____ **(Initials)**

Printed Name: _____ _____ **(Signature)** ____ **(Initials)**

Printed Name: _____ _____ **(Signature)** ____ **(Initials)**

Printed Name: _____ _____ **(Signature)** ____ **(Initials)**

Printed Name: _____ _____ **(Signature)** ____ **(Initials)**