**Northwest Christian Schools**
**HEALTH SERVICES**
5028 East Bernhill Road, Colbert, WA 99005
Email: healthoffice@nwcs.org
Telephone: 509-292-6700 x107
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# MEDICATION REQUEST FORM (HS-MED1)

Student Name: _____ Birthdate: _____

School: _____ Grade: _____

**TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY**

Name of Medication: _____ Dosage: _____

Time(s) of Day to Be Taken: _____ Route: _____

If given PRN, specify the length of time between doses: _____

Reason for Medication: _____

Possible Side Effects: _____

**Self-Carry Medication:** This student has demonstrated, to a LHP in my office, the ability to

Correctly administer this medication: ☐ Yes ☐ No

Student may carry medication on his/her person: ☐ Yes ☐ No

I request/authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) 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. Such medication may be administered by trained school personnel who have no formal medical education.

Date of Signature Signature (Licensed Health Professional with Prescriptive Authority)

Phone Number: Printed Name:

**NOTE: This form MUST be signed by a licensed health professional with prescriptive authority.**

**THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN**

I request/authorize the school to administer medication to the above-identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

Under limited circumstances, a student may self-carry medication. In this case an additional form will need to be completed by the parent, student and nurse (HS-MED2).

☐ I received a copy of NWCS Medication Administration Policy (HS-MED3).

☐ I acknowledge and accept NWCS Medication Administration Policy (HS-MED3).

☐ I understand that all medication must be picked up on the last day of school. Medication left behind will be disposed of.

☐ I certify that emergency medical information in ParentsWeb is complete and up-to-date.

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Signature Date: _____

Parent/Guardian Telephone Numbers: Cell: _____

Home: _____

Work: _____

School Nurse Signature: _____ Date: _____

☐ Medication (OTC or prescription) inspected: original container, not expired, properly labeled

☐ Staff entered into RenWeb / FACTS

☐ Medication and Medication Request Form(s) are stored in the Health Room / Front Office

Receiving Staff Member: _____ Date: _____