Northwest Christian Schools
HEALTH SERVICES
5028 East Bernhill Road, Colbert, WA 99005
Email: healthoffice@nwcs.org
Telephone: 509-292-6700 x107
Fax: 509-292-6713

MEDICATION REQUEST FORM

Student Name: _____ Birthdate: _____

- **1 medication per request form**
- If the student has asthma, a seizure disorder, or a life-threatening allergy, please complete an appropriate Care Plan
- The NWC Medication Policy and blank Care Plans can be found on the NWC website in the Parent Resource section

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROFESSIONAL (LHP)

Medication: _____ Dose: _____ Route: _____

Will this medication be given PRN? ☐ Yes ☐ No

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

If this medication is scheduled, please specify time(s) of day to be given: _____

Can this medication be self-administered? ☐ Yes ☐ No

Reason for medication: _____

Possible side effects: _____

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.

LHP Signature: _____ Date: _____

LHP Printed Name: _____ Phone: _____

NOTE: This form MUST be signed by a Licensed Healthcare Professional (LHP) with prescriptive authority to be valid.

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.

☐ I acknowledge and accept NWCS Medication Administration Policy.

☐ I acknowledge that all medication must be dropped off / picked up in the Front Office by an adult.

☐ I understand that all medication must be picked up on the last day of school.

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

Parent/Guardian Signature: _____ Date: _____

Printed Parent/Guardian Name: _____ Phone: _____

THIS PORTION TO BE COMPLETED BY NWCS STAFF MEMBER

☐ Medication Transfer Form completed by parent and staff member.

☐ Medication is safely stored in the Health Room or Front Office.

☐ Receiving staff member informed School Nurse via email, bkoler@nwcs.org.

☐ If applicable, a copy of this form was sent to the School Nurse at Lower Campus via interoffice mail.

Receiving Staff Member: _____ Date: _____