



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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SELF-CARRY MEDICATION REQUEST FORM

This form is for Upper Campus students / grades 7th – 12th ONLY

Student Name: _____

Birthdate: _____

- **1 medication per request form**
- This form cannot be used for controlled substances; please use a Medication 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, Medication Request Forms, 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 taken PRN: Yes No

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

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

Reason for medication: _____

Possible side effects: _____

This student demonstrated the ability to correctly administer this medication*: Yes No

* LHP must check "yes" to the above question in order for student to self-carry.

I request/authorize that the above-named student to self-administer 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.

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 STUDENT

SELF-ACKNOWLEDGEMENT

- I will only carry a one day supply of OTC/prescribed medication.
- I will keep a copy of this Medication Request Form with the medication.
- I will keep the medication in the original container.
- I will not share my medication with any other student or faculty/staff member.
- I will not leave my medication unattended where another person could access it.
- I will not use my medication for any other purpose than to treat my medical condition.
- I will only take this medication as ordered by my healthcare provider.
- I will go to the Front Office if I am having any adverse symptoms / problems.
- I acknowledge that this is a privilege that can be changed if I do not follow the above rules.

Student Signature: _____ Date: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

This signed document grants permission to the signed student to carry a one day supply of said medication according to Northwest Christian Schools Policy and Directive 3416. This also relieves Northwest Christian Schools of any responsibility for the benefits or consequences of the medication that is self-administered; this acknowledges that the school bears no responsibility for ensuring that the medication is taken.

- I acknowledge and accept NWCS Medication Administration Policy.
- 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

- Receiving staff member informed School Nurse via email, bkoler@nwcs.org.
- A copy of this form was sent to the School Nurse at Lower Campus via interoffice mail.

Receiving Staff Member: _____ Date: _____