Northwest Christian Schools
5028 E Bernhill Rd
Colbert, WA 99005
E: healthoffice@nwcs.org
P: 509.292.6700 ext 107
F: 509.292.6713

Self-Carry Medication Request Form

This form is for Upper Campus students (grades 7-12) 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 in lieu of this form.

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:_____

Reason for medication:_____

Possible side effects:_____

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.

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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.

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, mkershinar@nwcs.org.

Receiving Staff Member: _____Date:_____