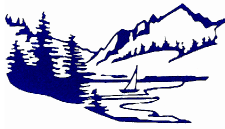

North Mason School District

3416 F1

71 E. Campus Drive, Belfair, WA 98528
(360) 277-2300 (360) 277-2320 FAX
David Peterson, Superintendent

MEDICATION AT SCHOOL

In order for children to receive medicine while at school or during school events, the following form (both parts A and B) must be completely filled out and returned to the school prior to its administration. Whenever possible, prescribed medications should be given before and/or after school hours under the supervision of the parent or guardian. Medication is to be furnished by parent/guardian in the original container from the pharmacy or in a new, sealed, over-the-counter container. The District shall manage medication as per District Policy and Procedure. ***NOTE: This request will expire at the end of the current school year***

A. HEALTH CARE PROVIDER'S ORDER FOR MEDICATION AT SCHOOL

I request the following student to be given medication at school as there is a valid health reason which makes the administration of medication advisable during the time a student is under supervision of school officials.

Student's Name ______________________ Grade ________ School ______________________

Medication to Be Administered ______________________ Dosage and Mode of Administration ______________________

Condition Being Treated ______________________ Time to Be Given at School ______________________

Inclusive Dates Medication Given ______________________ Side Effects of Drug to be Expected, if Any. *(What emergency measures if this occurs?)* ______________________

(HCP INITIALS)

Permission to carry and/or self-administer medication: ☐ *(requires District Nurse and/or Principal authorization.)*

****This student has demonstrated the ability to correctly administer this medication****

CONTROLLED MEDICATIONS MAY <u>NOT</u> BE SELF-ADMINISTERED

Health Care Provider's Name (Please Print) ______________________ Health Care Provider's Signature ______________________

Health Care Provider's Phone ______________________ Date ______________________

B. **PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL**: I request that the principal or a designated staff member give my child, ______________________ the medication prescribed by our health care provider,______________________.

(*Check the one that applies for the following situations*)

EARLY RELEASE: I ☐ **<u>do</u>** ☐ **<u>do not</u>** want the school to administer **<u>scheduled</u>** medication(s).

HALF DAYS: I ☐ **<u>do</u>** ☐ **<u>do not</u>** want the school to administer **<u>scheduled</u>** medication(s).

(PARENT INITIALS)

Permission to carry and/or self-administer medication: ☐ *(requires District Nurse and/or Principal authorization.)*

****This student has demonstrated the ability to correctly administer this medication****

I understand that my signature on this form constitutes a waiver for any liability that may occur in the administering/self-administering of this medicine at school. I am aware that self-administration of medications is a privilege and district procedures must be followed (copy available from school office). If a safety issue arises with self-administration, the School Administrator or Registered Nurse has the right to notify me and discontinue this privilege unless mandated by current legislation.

Signature of Parent or Guardian ______________________ Date ______________________

Work Phone ______________ Home Phone ______________ Military Sponsor's I.D. Number *(If Applicable)* ______________________

Rx Self-Administration authorization: ______________ ________ ______________ ________
(Required for Grades K-12) *Principal* *Date* *District Nurse* *Date*