North Mason School District

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

Parent Permission for Administration of Over the Counter Medication

Student's Name:_______________________________________ DOB:_________________
School:____ Grade:_________________________
Parent Phone:_____________________________________ School Year:_________________

Medication Start Date:______________ End Date:__________________

Procedure for Administration

I request and authorize that the above named student be allowed to receive the over-the counter medication listed below while at school for the period of ________________________ (Max. 14 days). There exists a valid health reason which makes administration of the medication(s) advisable. The medication is to be furnished by me in the original container and stored in a locked cabinet in the health room, unless given permission to self-administer and carry per policy.

Grades K-8 requires District Nurse and Principal permission to carry medication and self-medicate. If permission to self-carry is granted by the District Nurse and Principal, the "Parent Permission for Self-Administration of Over the Counter Medication" form must also be completed.

If the student requires the below medication for more than 14 days, a medication order must be received by the school from a health care provider for continued use. Reason for medication use must follow manufacturers and pharmaceutical recommendations unless overridden by a health care provider.

Medication	Dosage	Route	Time Given	Side Effects

Reason for Medication:____

Parent/Guardian Signature Date

District Nurse Signature Date