North Mason School District
71 E. Campus Drive, Belfair, WA 98528
(360) 277-2300 (360) 277-2320 FAX

PARENT PERMISSION FOR SELF-ADMINISTRATION OF OVER-THE-COUNTER MEDICATION

Student's Name: _____ DOB: _____

School: _____ Grade: _____

Parent phone: _____ School year: _____

PROCEDURE FOR SELF-MEDICATION

I request and authorize that the above named student be allowed to self administer the **over-the-counter** medication(s) listed below while at school or at school sponsored activities for the period of _____. There exists a valid health reason which makes administration of the medication(s) advisable. My student knows he/she must carry a completed written permission form. The medication is to be furnished by me in the original container. Only the number of doses required for each day or event will be sent. My signature indicates that I understand the school accepts no liability for untoward reactions from this self-administered medication, and have made my student aware of possible side effects. I have instructed my student when and how to take the medication. My student understands that by signing this form he/she agrees not to share medication with any other person. I understand that if a safety issue arises, the School Administrator or District Nurse has the right to notify the parent and discontinue the self-medication privilege.

CONTROLLED SUBSTANCES MAY NOT BE SELF-ADMINISTERED.

Grades K-8 requires District Nurse and Principal permission to carry medication and self-medicate.
(Permission will be based on medical need and will consider student safety.)

Name of Medication	Dosage	Route	Time Given	Side Effects

Diagnosis: _____

_____ _____
Student Signature Date Parent/Guardian Signature Date

_____ _____
Administrator Signature Date District Nurse Signature Date