# North Mason School District

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

## 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. In the event of a disaster or emergency that prevents children leaving the district, doses normally given by the parent/guardian beyond regular school times may be administered by school staff. 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 3416. **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 Time to Be Given at School

_____ _____
Inclusive Dates Medication Given Condition Being Treated

_____
Side Effects of Drug to be Expected, if Any. (*What emergency measures if this occurs?)*

_____ _____
**Health Care Provider's Name (Please Print)** **Health Care Provider's Signature**

_____ _____
**Health Care Provider's Phone** **Date**

**Permission to carry and/or self-administer medication** (requires District Nurse and/or Principal authorization.):
_____(HCP Initials) ***This student has demonstrated the ability to correctly administer this medication***
**CONTROLLED MEDICATIONS MAY NOT BE SELF-ADMINISTERED**

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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 _____.

**ON HALF DAYS or EARLY RELEASE** (*Check One*) _____I do want the school to administer **scheduled** medication(s).
_____ I do NOT want the school to administer **scheduled** medication(s).

**Initial here if you want medication refill reminders through email or Skyward: _____**

_____ _____
Signature of Parent or Guardian Date School Nurse/Principal Signature Date

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

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.

_____ _____
School Nurse/Principal Signature for Permission to carry/self-administer Date