Dear Parents,

To insure your student can have access to their medications not usually taken during school hours for school related activities (such as sports and field trips), please complete the following at least two weeks prior to the school related activity: 1) Permission to Carry Non-Prescription Medications (those that you can purchase over the counter) and/or 2) Authorization for Administration of Medication at School. These forms must be completed for **all** school related activities.

A physician signature is required for prescription medications before your student can have the prescription medication administered or in their possession. If you have already completed the forms for your student to have his/her medication at school, those forms do cover all school activities. Should your student have a medication that they have not been authorized to keep in their possession, the nurse will provide the appropriate training to allow a staff member to dispense the medication to your student while participating in the school related activity.

The staff and chaperones will not have medication that they can administer to your student unless you have provided the medication with the proper paperwork and training has been provided by the nurse.

Thank You,

Kristy Kelly R.N.

GPHS School Nurse

360-563-7507

3416F.4b

**PERMISSION TO CARRY**



**NON-PRESCRIPTION MEDICATION**

Snohomish School District No. 201, Snohomish, WA 98290

Snohomish School District Medication Policy allows students to carry and self-administer over-the-counter

(Non-Prescription) medication if the following criteria are met:

* A one-day supply only. (for overnight field trips, they are allowed a supply for each day)
* Medication is in the original container (check to be sure it is current or unexpired).
* A note is carried on the student, which is signed by the parent, indicating the student’s name,

the name and dose of the medication and the dates and times to be given.

* The approval of the Registered Nurse or other SSD nurse available.

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| Date: |  | | | |  | | | | |
| **I give permission for:** | | | |  | | | | | |
| **Medication**: | |  | | | | Dose/Frequency: | |  | |
| Reason for taking: | | |  | | | | Dates: | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication:** |  | | Dose/Frequency: | |  | |
| Reason for taking: | |  | | Dates: | |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Medication:** |  | | Dose/Frequency: | |  | |
| Reason for taking: | |  | | Dates: | |  |

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| R.N. Signature |  | Parent/Guardian Signature |

Washington State Laws authorize Snohomish School No. 201 to allow administration of prescription medication and/or in student’s possession during school hours. A written medication order from an authorized prescriber and written authorization from the parent/guardian is required.

Due to safety concerns each student is individually evaluated based on their health and developmental level. We reserve the right to discontinue administration of the medication if it becomes impracticable or unsafe, and/or withdraw permission to self-administer if the student demonstrates an inability to responsibly possess and self-administer such medication. The parent/guardian will be contacted as soon as possible and in advance of the discontinuation of the medication.

Medications must be in the original container dispensed by a physician/pharmacist and only a one day supply will be allowed in the student’s possession. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

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# ***Parent/Guardian Authorization***

**Name of Student:** **Sex:** **Date of Birth:** \_\_\_\_\_\_\_ \_

**Name of School:**\_ \_\_ **FAX #**: \_ **Grade:** **Teacher**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that the medications listed below be administered to my child by the District or, if approved by the prescriber, be self- administered by my child. This signed authorization will allow the District Nurse to contact my child’s Health Care Provider, who signs this authorization, regarding the condition for which this medication is being administered and use of this medication(s). I acknowledge that the District shall incur no liability as a result of any injury arising from the District’s administration of oral medications in substantial compliance with the prescription. I also indemnify and hold harmless the District and its’ employees or agents against any claims arising out of the self-administration of this medication by my child.

**Parent/Guardian Signature:** \_\_ **Date:** \_\_\_\_\_\_\_ \_

**Home Phone:** ( ) **Emergency Phone:** ( ) \_

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***Prescriber’s Authorization***

Condition for which medication is being administered: \_

Authorized to Self-Administer

1. Medication: Dose: \_\_\_\_\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_ ❒\* Yes ❒ No

2. Medication: Dose: \_\_\_\_\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_ ❒ \*Yes ❒ No

3. Medication: Dose: \_\_\_\_\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_ ❒ \*Yes ❒ No

Side Effects: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*A trained staff member may assist in the administration this medication in the event my child is unable to self-administer.

**If I have checked “yes” above, I verify that the student has demonstrated to me the skill level necessary to use the medication and the device necessary to administer the medication.**

There exists a valid health reason which makes administration of medication and/or in possession of this medication by the student advisable during school hours or during such time that the student is under the supervision of school officials for the period commencing with\_\_\_\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_ through the\_\_\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_\_\_\_. This request is valid no longer than the current school year.

I accept responsibility for monitoring the medication prescribed for desired or adverse side effects. I will be monitoring the ongoing health status of this patient. If prescription medications are listed above, they are within the scope of my prescriptive authority.

**Licensed Health Care Provider Signature:** **Date:**  \_

**Printed Name: Phone: ( ) FAX: ( ) \_**

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### I, District Nurse, verify that the student has demonstrated to me the skill level necessary to use the medication and the device necessary to administer the medication and agree that the student should be in possession of his/her medication during school hours.

**Date: Signature of District Nurse (RN): \_**

I, School Principal, agree that student shall be in possession of his/her medication during school hours.

**Date: Signature of Principal: \_**

**This authorization does not exceed the current school year.**