Marysville School District

Health Services
4220 80th ST NE
Marysville, WA 98271
Phone: 360-965-2059 Private Nurse Fax: 360-965-2046

ADMINISTRATION OF OVER-THE-COUNTER AND PRESCRIPTION MEDICATION AT SCHOOL
RCW 28A.210.260 and 28A.210.270

Student Name: _____ Birth Date: _____ Teacher _____

School: _____ FAX: _____

HEALTH CARE PROVIDER completes this section: (please print)

Name of Medication: _____
Trade Name **Generic Name** **Dosage**

Administration: (e.g., 1 tablet at 12:00 noon, lunch) _____

_____

Reason for Medication: _____

Length of Prescription Period: **From** _____ **Through** _____
(not to exceed the extended school year)

Significant side effects. _____

_____ **Date:** _____ _____
Physician signature **Telephone**

_____ _____
Name (Print) **FAX**

PARENT/GUARDIAN completes this section.

I request that my child be allowed to take the medication as prescribed above.
I request authorized school staff assist my child in taking the medication(s) described above.
I understand school staff will attempt to administer medication in a timely manner. I also understand, due to scheduling and other circumstances, it is possible for a dosage to be delayed or missed.
I will provide the medication in the original, properly labeled container.
I understand for the protection of all students, an adult is responsible for the delivery and pick up of all medications.
I give my permission for the exchange of information between school staff and health care provider.
I understand my signature indicates my understanding the school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and in accordance with the District Policy and Procedure 3416 and 3419.

_____

Parent/guardian signature Phone Date