FERNDALE SCHOOL DISTRICT NO. 502
Ferndale, WA 98248

AUTHORIZATION FOR SELF ADMINISTRATION OF OVER-THE-COUNTER MEDICATION AT SCHOOL

Name of Student _____ Birth Date _____

School_____ Teacher_____

THIS PORTION TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I believe it is in my child's best interest to self medicate and I authorize him/her to self administer, in accordance with the instructions indicated below. I understand that:

1. This written authorization form must be signed by me indicating the dosage of the medication and dates and times it is to be taken. A copy of the form must be in the office of the school before the student begins taking the medication.

2. The student will carry only one day's dosage of the medication.

3. The school will assume no responsibility or liability for the administration of the medication.

4. I have instructed my student on how to use this medication and that it is only for his/her own use.

Name of Medication: _____

Dosage: _____

Time(s) of Dosage(s): _____

Anticipated action of Medication: _____

Length of Prescription Period: From _____ To _____

Possible side effects:_____

Emergency measures in case of serious side effect: _____

Parent/Guardian Signature _____ Date _____

_____ _____

Telephone Number (home) Telephone Number (work)

THIS PORTION OF FORM TO BE COMPLETED BY THE STUDENT

1. I have been instructed in the proper use of this medication by my parent/health care provider.

2. I understand this medication is for my own use only and not to be shared or given to other students.

Student Signature_____ Date _____

THE COMPLETED FORM MUST BE RETURNED TO THE SCHOOL OFFICE PRIOR TO THE STUDENT BEGINNING SELF MEDICATION.