Authorization for Medication Administration by School Personnel

Complete and Return to School

To Principal of _____
School Name

Student Name:_____ DOB:_____ Grade:_____ Teacher:_____

I am giving school personnel **permission** to administer medications to my child per the following (**Complete** all underlined sections):

Medication's Name:

Dose (prescribed amount, e.g. 5 mg., **not** 1 pill)

Tablets requiring cutting should be cut by the parent before being brought to school. Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent.

Route: **(circle one)**:
By: Mouth Ear Eye Nose Skin Inhalation

Time of day to be given at school (e.g. 11 a.m., **not** mid day)

Duration: Start date_____ end date_____

Reason for Medication:

Special Instructions:

☐ Please allow my child to self-administer this medication. Refer to district policy on self-medication). *Requires self-medication agreement form to be signed by parent, school administrator, and if prescription, consent of physician[1]. (See below)*

Check One:

☐ Prescription Requires physician direction (see below[1])

☐ Non prescription

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.

PRESCRIPTIONS MUST BE WRITTEN BY OREGON-LICENSED PHYSICIANS.[1]

☐ Other (Describe)

I understand: I am responsible **to provide this medication** and maintain the supply as needed; to **notify the school** in writing of any changes in the medication or prescriber; to **pick up** all unused medication by the last day of school (or it will be discarded); this authorization is **valid no longer than one year** from this date and applies only to the medication above; this **authorizes an information exchang**e, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

Parent/Guardian Signature:_____ Date:_____

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OREGON LICENSED PHYSICIAN DIRECTION[1]

(Required in writing or on pharmacy label for all prescription medications per OAR 581-021-0037[1]).

☐ I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.
☐ Please allow this student to carry and self-administer this medication. (Must be allowed by school district policy. Student must be developmentally and behaviorally able to self-administer.)
☐ Special instructions including adverse reactions and action required:_____

_____

_____ _____
Oregon-Licensed[1] Physician's Name (please print/stamp) Address

_____

_____ _____ _____
Oregon-Licensed[1] Physician's Signature Phone # Effective Date