School District Name

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY DESIGNATED SCHOOL PERSONNEL

Student’s name: Birthdate: Grade:

I give school personnel permission to administer this medication per the following instructions: (Do not skip any questions)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medication: | | | | | Start Date: | End Date: |
| Dose (Strength/how much): | | | | | Non Prescription |  |
| Frequency (how often): | | | | | Prescription |  |
| Time of day for meds at school: | | | | | Pharmacy Name: | |
| Route (circle one): | | |  |  | Prescription Number (if applicable): | |
| Mouth | Ear | Eye | Nose | Skin |  |  |
| Prescriber Name (if applicable): | | | | | | |
| Reason For Medication: | | | |  | Prescriber Phone (if applicable): | |
| Special Instructions: | | | |  | **ALL MEDICATION MUST BE IN ITS UNEXPIRED, ORIGINAL CONTAINER** | |
|  | | | |  | **WITH ACCURATE LABEL** | |

I understand I am responsible to provide this medication and maintain the supply as needed. All medication must be provided from home and must be contained in its original, labeled and unexpired container. I understand that I am responsible to notify the school in writing of any medication changes, and that all staff-administered medications are to be brought to and from school by a parent/guardian or student when allowed. All unused medication must be picked up by the last day of school. I understand that any medication left at school will be discarded. (OAR 581-021-0037)

**Parent/Guardian Signature:**  **Date:**

**PRESCRIBER DIRECTION**

(Required in writing or on pharmacy label for all prescription medication and non-FDA approved medications)

I have prescribed the above medication for the student whose name appears on the top of the form Instructions from the parent are accurate

Please allow this student to carry and self-administer this medication. (Student must be developmentally and behaviorally able to self-administer)

I certify that this medication is necessary for the student to remain in school

Special instructions including adverse reactions and action required:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | | | | |
| Prescriber’s Name (please print/stamp) | Clinic Name and Address | | | | |
| Prescriber’s signature |  |  | Phone |  | Effective Date |