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:___________________________

Dose (Strength/how much):______________

Frequency (how often):_________________

Time of day for meds at school:__________

Route (circle one):
Mouth Ear Eye Nose Skin

Reason For Medication:

Special Instructions:

Start Date:__________ End Date:___________

______Non Prescription

______Prescription

Pharmacy Name:_______________

Prescription Number (if applicable): ______________

Prescriber Name (if applicable): _________________

Prescriber Phone (if applicable): _________________

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 (or student) 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