BEAVERTON SCHOOL DISTRICT
THRIVE • CONTRIBUTE • EXCEL

MEDICATION AUTHORIZATION FORM

Student: _____ **ID#:** _____ **DOB:** _____

School: _____ **Grade:** _____ **Date:** _____

I request that the below listed medication(s) be administered to my child during the school day per Beaverton School District medication policy. I have been offered the *Medication Information for Parents*.

_____ _____
Parent/guardian signature Daytime Phone(s)

_____
Signature of staff receiving medication

Medication: _____ Dose: _____ Time(s) given: _____

Prescription Medication Amount Counted: _____ Staff Initial: _____ Exp. Date: _____

Purpose: _____ Additional Info: _____

Medication: _____ Dose: _____ Time(s) given: _____

Prescription Medication Amount Counted: _____ Staff Initial: _____ Exp. Date: _____

Purpose: _____ Additional Info: _____

Medication: _____ Dose: _____ Time(s) given: _____

Prescription Medication Amount Counted: _____ Staff Initial: _____ Exp. Date: _____

Purpose: _____ Additional Info: _____

Comments: (additional medication sign-in, medication sign-out, parent contact, and other documentation)

Date/Information/Staff initials: _____