



# Philomath Public Schools

Benton County School District 17J, 1620 Applegate Street, Philomath OR 97370 (541) 929-3169

## Authorization for Medication Administration by School Personnel

**Parent or Physician to complete:**

Student name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Medication: \_\_\_\_\_

Circle one: Non Prescription (OTC)      Prescription (# count: \_\_\_\_\_) Initials \_\_\_\_\_, \_\_\_\_\_

Dose (how much): \_\_\_\_\_

Frequency (how often): \_\_\_\_\_

Route (circle one):    Mouth            Ear            Eye            Nose            Skin

Time medication is to be administered: \_\_\_\_\_

Duration: Start date: \_\_\_\_\_      End date: \_\_\_\_\_

Reason for medication:  
\_\_\_\_\_

Special Instructions: \_\_\_\_\_

**Physician Signature** (if indicated)

\_\_\_\_\_

### ALL MEDICATION MUST BE IN ORIGINAL CONTAINER

\*If your student will be self-medicating during the school day and/or school event, please fill out the "Self-Medication" permission form and agreement.

\_\_\_\_ Please send this medication on field trips that overlap dosage times.

**I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes.**

Parents are required to pick up all unused medication by the last date of school. All medication left at the school will be discarded.

\_\_\_\_\_  
Parent /Guardian signature

\_\_\_\_\_  
Date

**This authorization applies only to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and /or my child's health provider.**