ESTACADA SCHOOL DISTRICT
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Authorization for Medication Administration by School Personnel

Student Name:_____ **Grade:**_____ **DOB:**_____

School:_____ School Year: _____

☐ **I am giving school personnel permission to administer the following medications:**

*If this medication is an Epi-pen, or other epinephrine auto injector, for the treatment of anaphylaxis, it is strongly recommended that you provide the school with a primary and back-up injector.

Medication name:

Dose*: (example: "5 mg". Not "1 pill")

**Tablets requiring cutting need to be cut by the parent before being brought to school. Dosage spoons for liquid medications, or other measuring devices are to be supplied by the parent.*

Method of Administration: (circle one or explain)
Mouth Ear Eye Nose Inhalation
Intramuscular Rectal Skin

Time of day/ Frequency of Administration:
(example: "11am", not "mid-day")
As needed or specific time:_____

Check One:

☐ **Prescription #**_____
ALL MEDICATION MUST BE IN ITS NEWEST, ORIGINAL CONTAINER WITH PHARMACY LABEL ATTACHED TO THE CONTAINER.
PRESCRIPTIONS MUST BE WRITTEN BY OREGON-LICENSED PHYSICIANS ONLY.

☐ **Non-prescription**: **STUDENTS NAME MUST BE WRITTEN CLEARLY ON THE CONTAINER.**

☐ **Special instructions:**

Duration: Start date_____ End date_____ or ☐ last school day of current school year.

Reason for medication: (circle one or explain)
Asthma Allergic reaction Pain control Infection ADD/ADHD Seizures Diabetes Other:

PARENT: I understand that I am responsible to: provide this medication and maintain the supply as needed; notify the school in writing of any changes in the medication or prescriber; and to pick up all unused medication by the last day of the school year or within 5 days of the end of the medication period, or it will be destroyed/discarded. This authorization is valid only for the current school year and applies only to the medication above. This authorizes an information exchange, as necessary, between the district nurse, appropriate school personnel, and /or my child's health provider.

Signature:_____ Date:_____

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Office Use Only
Method of Medication Disposal
❑ Returned to parent.
❑ Disposed of per district policy.
Date: Initial: Initial:

Student Name:_____ DOB:_____ Phone:_____

Student on an IEP? ☐Yes ☐ No

Medication:_____ Dose:_____ Route:_____
(Only one medication per form) Frequency:_____ Time:_____

School: ☐ Clackamas River Elementary; ☐ River Mill Elementary; ☐ Estacada Middle School; ☐ Estacada High School

The five R's of Medication Administration: 1. Right NAME of student 2. Right MEDICATION 3. Right DOSE 4. Right TIME 5. Right ROUTE

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SEP																															
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A= Absent; **D**=Early Dismissal; **L**=Late arrival; **/** = No School; **O**=No show; **W**=Withheld*; **PC**=Parent contact; **R**=Refused*; **DM**=Dose missed*; **N**=No med available*; **DW**=Dose wasted*. ***Parent contact and documentation/comment required.**

Severe reaction to any medication: If student has breathing problems, rash develops, difficulty swallowing, swelling of face/tongue/mouth, intense itching, vomiting, call parent and 911 immediately.

Authorized Medication Administrators: (MUST be signed by anyone dispensing this medication to this student)

Initials:	Staff Signature:	Initials:	Staff Signature:	Initials:	Staff Signature:

Medication sign-in / sign-out: (FT – to teacher for field trip/activity; P – Parent)

Date:	Medication Name:	Amount Received:	Amount Returned:	Staff Signature:	Parent (or Staff) Signature: