Every Student a Graduate Prepared for a Bright and Successful Future
Springfield Public Schools

SPS Health Services
Springfield High School Campus
1050 10th Street * Springfield Oregon 97477
* Phone 541-744-4131 *Fax 541-744-4822

Authorization for Medication Administration By School Personnel

Student:__________________________________ DOB:__________ School:____________________

Teacher &/or Grade:____

I give school personnel permission to administer medication(s) to my child per the following instructions for the

________________________ school year.

***Please make sure these instructions match the prescription label and/or the manufacturer's instructions.**
***Medication MUST match description on label.**

Medication: ____

Dose (how much?): ________________________ mg / ml

Frequency (how often?): ______________________________

Route (circle one): Mouth Ear Eye Nose Skin Other: ___________________________

Time(s): ___________________________ Start Date: _______________ End Date: _______________

Reason for medication: ____

Special Instructions: ____

____

❑ Please allow __________________________________ to self-administer this medication (refer to district policy on self medication).

_________ (Initial Here) I understand that I am responsible to provide this medication and maintain the supply as needed. It is the parent/guardian's responsibility to inform the school IN WRITING if any changes are made to medication instructions. This includes written instruction from parent/guardian and prescribers. A new pharmacy label needs to be provided to the school, if applicable. I understand I am required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

_________ (Initial Here) I give my permission for the Springfield Public School District to obtain information from my child's

physician regarding his/her medication(s) for the current school year. ______________________________________
(Doctor prescribing medication or primary physician)

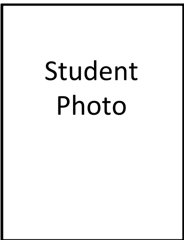
I understand this information will not be shared with agencies or individuals other than those indicated. I further understand that my consent is voluntary and may be revoked at any time.

______________________________________ ______________________________
(Signature) (Date)

______________________________________ ______________________________
(Printed Name of Parent/Guardian) (Relationship to Student)

____________________ ____________________ ____________________
(Home Phone) (Work Phone) (Cell Phone)

Student:____ DOB:_______________________________________



Comments (initial/Date/Time all comments):____

____

____

Intials	Nurse/Staff Signature	Initials	Nurse/Staff Signature	Intials	Nurse/Staff Signature	Intials	Nurse/Staff Signature

* Required Comments + Parent Contact Required

O=No Show+ **W**=Withheld+* **PC**=Parent Contact **R**=Refused+ **A**=Absent **DM**=Dosed Missed+* **N**=No Med.+ **D**=Early Dismissal **L**=Late Arrival **S**=Suspension **DW**=Dose Wasted* **NS**=No School

Month	Medication	Scheduled		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
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