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: _____

Dose (How much): _____

Frequency (How often): _____

Route: ☐Mouth ☐Ear ☐Eye ☐Nose ☐Skin

Time medication is to be administered: _____

Duration: Start date: _____ End date: _____

Reason for this medication: _____

Medication count at drop-off: _____ Staff Initials: _____

Special Instructions: _____

☐ Please send this medication on field trips.

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 Agreement" form.

I understand that I am responsible for providing this medication and maintaining the supply as needed. I understand that I am responsible for notifying the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school office 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.

For Office Use Only

Name: _____ **Medication:** _____

Dose: _____ **Time:** _____ **Teacher:** _____

Medication Log

Date	Time	Initial	Code		Date	Time	Initial	Code		Date	Time	Initial	Code

Receiving Medication

Amount	Staff Signature	Parent Signature	Date

Medication Error

Explanation	Staff Signature	Staff Signature	Date

Medication Returned to Parent

Medication	Amount	Staff Signature	Parent Signature	Date

(A) Absent (R) Refusal (E) Early Dismissal (F) Field Trip (X) No School (N) No Medication Available