BEAVERTON SCHOOL DISTRICT

MEDICATION AUTHORIZATION

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: _____

STUDENT MEDICATION RECORD

Staff Signature / Initials: ______________________ Staff Signature / Initials: ______________________

Staff Signature / Initials: ______________________ Staff Signature / Initials: ______________________

Six Rights of Medication Administration:
- Right Student
- Right Medication
- Right Route
- Right Time
- Right Dose
- Right Documentation

A = Absent = See Comments

Month	Medication / Dose	Time	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