Authorization for Medication Administration by School Personnel

Right Student	**Student's Name:**	**Date of Birth:**
Right Medication	**Name of Medication:**	
Right Dose	**Dose of Medication** [*in mg or units, for example, not "1 pill"*] (**How much):**	
Right Reason	**Reason for Medication (why is medication needed):**	
Right Route	**Route of Medication**: ☐Oral (by mouth) ☐ Cutaneous (Skin) ☐ Inhaled ☐ Otic (ears) ☐Ocular (eyes) ☐Nasal (Nose) ☐Sublingual (under the tongue) ☐Buccal (In the cheek) ☐ Inhaled ☐Transdermal (patch) Separate Authorization for associated procedures: ☐Nebulized ☐ Rectal Medication ☐ Injectable	
Right Time	**Daily Medication: Time to be given**:	
	Frequency of Medication (how often):	**Duration of Medication (how long):**
	☐**As needed Medication "PRN": Conditions under which medication should be administered:**	
Prescription	**Consistent with:** ☐Pharmacy Prescription Label ☐Doctor's Written Order	
Non-prescription	**Consistent with:** ☐Commercially Prepared Medication Label	
Self-Medication	☐Please allow my student to self-administer this medication (Complete S*tudent Self-Medication Agreement* on back of this form)	
Authorization	*I hereby grant my permission to the school district and designated employees to administer the above prescribed medication to my child during the school day and during school sponsored activities. I understand it is my responsibility to refill mediation and provide the school with a new medication authorization and written update of medication changes*.	
	Parent/Guardian Signature	Date:
School Staff (Initial)	______form completed/correct _______medication received as required ______Inventory ______Medication Administration Record _____ Referral to RN	

Medication administered at school must be necessary for the student to remain in school and may only be administered exactly as prescribed or as designated on the container. [OAR 581-021-0037]. Written parental authorization is a requirement for medication administration in the school setting. Unexpired medication must be brought to school by the parent in the original container with an intact prescription or commercial label.

Student Self-Medication Agreement

Students who are developmentally and/or behaviorally able, will be allowed to self-administer medication, subject to the following:

1. This Self-Medication Agreement form must be submitted for all self-medication.
   - Self-administration of non-prescription medication requires this form and permission from a school administrator. Self-administration of non-FDA approved medication must also include a written order from a prescriber.
   - Self-administration of prescription medication requires this form, and permission from a school administrator and either a RN practicing in the school setting or a prescriber. Prescriber consent can be included on the prescription label or on this self-medication agreement form.
2. All medication must be kept in its appropriately labeled, original container as follows:
   - Prescription labels must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions.
3. Sharing and/or borrowing of medication with another student is strictly prohibited.
4. Permission to self-medicate may be revoked if the student violates school district policy governing administration of medication and/or these regulations. Additionally, the student may be subject to discipline, up to and including expulsion, as appropriate if the self-medication policy is violated.

Name of Medication:

STUDENT:

I have read and agreed to the above criteria given to me to carry and administer my own medication at school.

Student Signature: **Date:**

PARENT:

I agree to the above criteria and allow my student to carry and administer their own medication at school.

Parent Signature: **Date:**

SCHOOL ADMINISTRATOR:

I agree that the student is behaviorally and developmentally capable of carrying and administering their own medication at school.

Administrator Signature: **Date**

PRESCRIBER OR SCHOOL NURSE:

I have assessed this student and they understand when and how to use their medication appropriately**.**

Prescriber or RN Signature: **Date**

This student will:

☐Self-carry medication only
☐Self-Carry and self-administer medication
☐Keep medication in the office, but self-administer medication