Authorization for Medication Administration by School Personnel

Student Name:_____ DOB:_____ Grade: ___

School Name:_____ Teacher: _____

I am giving school personnel permission to administer the following medication to my child (complete all sections):

Medication Name: Dose/amount (for example, 5 mg, **not** 1 pill) Method of administration **(check one)**: By: ☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin ☐ Inhalation ☐ Rectal ☐ Intranasal (Additional training required) Time of day to be given at school: Duration: start date end date Reason for Medication:	Check One: ☐ Prescription - Requires physician direction (see below[1]) ☐ Nonprescription – must follow manufacturer's recommended dosing guidelines, otherwise requires prescription Special Instructions:

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ALL MEDICATION MUST BE IN THE MOST RECENT ORIGINAL PHARMACY OR MANUFACTURER'S CONTAINER WITH AN ACCURATE LABEL AND MUST NOT BE EXPIRED. TABLETS REQUIRING CUTTING ARE TO BE CUT BY THE PARENT/GUARDIAN OR PHARMACIST BEFORE BEING BROUGHT TO SCHOOL. LIQUID MEDICATION REQUIRES A DOSAGE SPOON/CUP (AVAILABLE AT YOUR PHARMACY). MEDICATION THAT MUST BE CRUSHED REQUIRES A PILL CRUSHER (AVAILABLE AT YOUR PHARMACY) AND A SUBSTANCE TO MIX POWDER INTO (TO BE PROVIDED BY PARENT/GUARDIAN).

PRESCRIPTIONS MUST BE WRITTEN BY AN OREGON PRESCRIBER, AND HAVE A PHARMACY LABEL THAT INCLUDES[1]:

- Student name
- Medication name
- Dose
- Time/frequency of administration

_____ _____

Oregon-licensed[1] prescriber's name Phone number

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My signature below confirms my responsibility: to provide this medication and maintain the supply as needed; to notify the school in writing of any changes to the medication or prescriber; to pick up all unused medication by the last day of school (or it will be destroyed). This authorization is valid only until the end of the current school year and applies only to the medication above. My signature below **authorizes an exchange of information**, as necessary, between the school nurse, necessary school personnel, and the student's healthcare provider.

Parent/Guardian/Student Signature:_____ Date: _____

[1] **Required in writing or on pharmacy label for all prescription medications per OAR 581-021-0037**