



AUTHORIZATION FOR MEDICATION ADMINISTRATION BY DESIGNATED SCHOOL PERSONNEL

Student name: _____ **Birthdate:** _____ **Grade:** _____

I give school personnel permission to administer this medication per the following instructions: (Do not skip any questions.)

Medication: _____ Start Date: _____ End Date: _____

Dose (Strength/how much) : _____ Prescription _____ Non-Prescription _____

Frequency (how often): _____ Pharmacy Name: _____

Time Medicine is Due at school: _____ Prescription # (if applicable): _____

Route (circle one): Mouth Ear Eye Prescriber Name _____

Nose Injection Skin Prescriber Phone # (if applicable): _____

Reason For Medication: _____

Additional Instructions: _____

**ALL MEDICATION MUST BE UNEXPIRED, IN THE ORIGINAL CONTAINER,
WITH ACCURATE LABEL**

I understand I am responsible to provide this medication and maintain the supply as needed. All medication must be provided from home and must be contained in its original, labeled and unexpired container. I understand that I am responsible to notify the school in writing of any medication changes. All staff-administered medications are to be brought to and from school by a parent/guardian or student when allowed. All unused medication must be picked up by the last day of school. I understand that any medication left at school will be discarded. (OAR 581-021-0037)

Parent/Guardian (or student) Signature: _____ **Date:** _____

PRESCRIBER DIRECTIONS

(Only required if prescription medication does not have pharmacy label Or for non-FDA approved medications)

*I have prescribed the above medication for the student whose name appears on the top of the form.

*Instructions from the parent are accurate.

*Please allow this student to carry and administer this medication. (The student must be at appropriate level of development and self-management behavior.)

*I certify that this medication is necessary for the student to remain in school.

*Special instructions including adverse reactions and action required: _____

Prescriber's Name (please print) _____

Prescriber's Clinic Name and Phone Number _____

Prescriber's Signature _____ Date _____

HRCSD Medication Administration Log

Student:	DOB:	School:	Year:
Medication:	Dose:	Route/Instructions	Time:

Month	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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Print Name:	Initials:																			Medication Name:				Arrival Date:				Initial Count:				Initials:												
								Key: ER: Error NS: No School or Leave Blank R: Refused/declined O: No Medication Available																																				