HILLSBORO SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

Student: _____ Birth date: _____ ID #: _____ School: _____ Grade: _____

PLEASE FILL OUT FOR ALL MEDICATIONS

Name of medication: _____ Prescription number (unless OTC*): _____

Mg per tablet or teaspoon: _____ Dosage to be given: _____

Provider's name: _____ Provider's phone number: _____

Hours between doses: _____ Amount in container: _____

Given at home in the morning? Yes / No When: _____ Double initials for controlled substance count: 1._____ 2._____

Time(s) to be given at school: _____ Discontinue date is end of the school year? Yes / No When: _____

Reason for medication to be given at school: _____

Special instructions: _____ Medication expiration date: _____

Student to carry medication? Yes / No (**Must have completed Self-Administration form and District Nurse permission.)**

*Over-the-counter medication

I hereby request and authorize school staff to give this medication in accordance with the instructions provided on the prescription label or OTC label. Staff cannot deviate from the directions provided on the label without a letter from the doctor. I understand that school staff will not be held liable for administering this medication. I authorize the school to release this information to appropriate staff members. I have been offered the Medication Information for Parents sheet. **I also authorize the release and exchange of information with the Oregon licensed medical professional/provider regarding this medication.**

Date: _____ Parent Signature: _____ Home phone: _____ Work phone: _____

Parent Name (Print): _____

REFILL INFORMATION

Date: _____ Prescription Number: _____ Exp. Date: _____ Count: _____ Staff Initials: _____

Parent Signature: _____

Date: _____ Prescription Number: _____ Exp. Date: _____ Count: _____ Staff Initials: _____

Parent Signature: _____

Date: _____ Prescription Number: _____ Exp. Date: _____ Count: _____ Staff Initials: _____

Parent Signature: _____

Date: _____ Prescription Number: _____ Exp. Date: _____ Count: _____ Staff Initials: _____

Parent Signature: _____

DISCONTINUE MEDICATION*:

***Any changes to the medication dosage or direction require a NEW medication authorization and medication administration.**

Date: _____ Pill count returned to parent:_____ Staff Initials: _____ Parent Signature: _____

Staff printed name and initials: _____ _____

_____ _____

Medication Review/RN Signature: _____

HILLSBORO SCHOOL DISTRICT
MEDICATION INFORMATION FOR PARENT/GUARDIAN

Home is the best place for your student to receive medication. If possible, spacing of medication dosages should be arranged to allow for home administration. We realize some students have health conditions that necessitate medication be given during the school day. The HSD Emergency Guidelines will be followed, and 911 will be called to assess any student receiving rescue medications. HSD follows state guidelines for medication administration. Listed below is information about the medication policy that should be reviewed to help ensure the school has the proper information to administer the medication safely and appropriately.

***ALL* MEDICATIONS**	**PRESCRIPTION MEDICATIONS**	**NON-PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS**
• Must be in the original container • Must be transported to and from school by the parent/guardian • Necessary paperwork must be completed by the parent/guardian (forms are in the office) • Adequate amount of medication is provided by the parent/guardian • Any and all changes in instructions for administration must be in writing, and cannot be accepted verbally • Medication not picked up by the parent/guardian at the end of the school year will be disposed of by school staff. **BEFORE OR AFTER SCHOOL MEDICATIONS:** • If your student attends any before or after school program on the premises when the office is closed, medication will NOT be available. • ***It is recommended that you provide an additional or back-up rescue medication to the individual program***	*In addition to the policies for ALL MEDICATIONS:* • Must have a current prescription label • Label must have the student's name, medication name, route of administration, dose, amount to be given at school, frequency/time of administration, and the Oregon licensed health care professional/ provider's name • Most pharmacies will provide two containers for prescription medication; one for home and one for school **SELF-ADMINISTRATION OF PRESCRIPTION MEDICATIONS:** *In addition to the policies for PRESCRIPTION MEDICATIONS:* • Signed parent permission and provider and/or District Nurse approval is required • ***HSD requests the parent/ guardian provide an additional or back-up inhaler or epinephrine auto-injector to be kept in the office when the student is carrying these medications***	*In addition to the policies for ALL MEDICATIONS:* • Must be in the original container with original label • Written provider order needed only when the parent/guardian's instruction for medication administration contradicts the safe dosing instruction on the label • Student name must be attached to the original container **NON-FDA APPROVED MEDICATIONS:** *In addition to the policies for NON-PRESCRIPTION MEDICATIONS:* • Requires a written order from a provider with directions for use, purpose, and a statement that the medication must be administered during school hours **SELF-ADMINISTRATION OF NON-PRESCRIPTION or NON-FDA APPROVED MEDICATIONS:** *In addition to the policies for NON-PRESCRIPTION MEDICATIONS:* • Signed parent/guardian permission and provider and/or District Nurse approval is required

Please refer to the Hillsboro School District website for a complete list of HSD Medication Board Policies for Prescription and Non-Prescription Medication: JHCD, JHCDA, JHCD-AR

HILLSBORO SCHOOL DISTRICT

HILLSBORO SCHOOL DISTRICT
MEDICATION SELF-ADMINISTRATION FORM

Student: _____ Birthdate: _____ ID #: _____

School: _____ Grade: _____

Medication(s): _____

A student may be allowed to self-administer a medication for asthma, diabetes, hypoglycemia, or severe allergies as prescribed by an Oregon licensed health care professional, upon written and signed request of the parent/guardian and subject to age-appropriate guidelines. This self-administration provision also requires a written and signed confirmation that the student has been instructed by the Oregon licensed health care professional on the proper use of and responsibilities for the prescribed medication. (JHCD, JHCDA)

A student may be allowed to self-administer a prescription or non-prescription medication with signed parent permission and signed provider and/or District Nurse approval.

- Parent/Guardian will bring medication to school and complete the applicable forms.
- ***Medication will be kept in its appropriately labeled, original container.***
- ***Student will CARRY ONLY THE AMOUNT OF MEDICATION NEEDED FOR ONE SCHOOL DAY.***
- Student will not share this medication with another person.
- Student will only self-administer the medication as needed, per label or prescription.
- Student agrees to inform staff if they experience any adverse reactions. (Example: nausea, vomiting, rash, difficulty breathing, dizziness, itching, etc.)
- *HSD requests the parent/guardian provide a back-up inhaler or epinephrine auto-injector, to be kept in the office,* when the student is carrying these medications.
- *If your student attends a before or after school program on the premises when the office is closed, the back-up medication will NOT be available*. HSD recommends that you provide an additional back-up epinephrine auto-injector or inhaler to the individual program.

The HSD Emergency Guidelines will be followed, and 911 will be called to assess any student receiving rescue medications.

Permission to self-administer medication may be revoked if the student violates HSD regulations and policies. Student may be subject to discipline, up to and including expulsion, if the above rules are violated. (JHCD, JHCDA, JHCD-AR)

I have read and agree to the above criteria and give permission for my child to carry and self-administer this medication. If applicable, my child has received proper instruction by a licensed healthcare professional to administer this medication.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

District Nurse/Provider Signature: _____ Date: _____