



Central Point School District #6

300 Ash Street, Central Point, Oregon 97502

541.494.6200 www.district6.org

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL

Student Name _____ D.O.B. _____

Parent/Guardian _____ Phone _____ Cell _____

Physician Name _____ Phone _____

Instructions provided by your doctor are needed in order for your student to take prescription medication at school. This is obtained from the prescription label. Only medication in the original container with a prescription label will be accepted. All over-the-counter medication must be accompanied by the parent/guardian's signature, complete instructions, and must be in the original container.

I am giving school personnel permission to administer medications to my child as per the following:

Parent/Guardian: please complete the following:

Medication (name and strength): _____ _____ Dose (how much): _____ Frequency (how often): _____ How given (circle one): By Mouth Ear Eye Nose Skin Time of Day: _____ Duration: Start Date _____ End Date _____ Reason for Medication: _____ _____ Special Instructions (such as give crushed in food or liquid): _____ _____	☐ Non-prescription ☐ Prescription Rx Number _____ ☐ Please allow my child to self-administer this medication. (Refer to district policy on self medication) ☐ Possible medication side effects: _____ _____
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I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing **of** any changes.

This authorization applies only to the medication listed above for the duration of treatment or school year. This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child.

Parent/Guardian Signature _____ Date _____

01/2025