



DATE: _____ SCHOOL: _____ SCHOOL YEAR: _____

Student Name:	Birth Date:	Perm ID:	Grade:
Parent/Guardian:	Relationship to student:	Phone:	
Parent/Guardian:	Relationship to student:	Phone:	
Emergency Contact:	Relationship to student:	Phone:	
Medical Provider:	Medical Organization:	Phone:	
Consulting Nurse:		Phone:	

Medication Name:		Type: <input type="checkbox"/> Prescription <input type="checkbox"/> Over the counter		Prescription number (if applicable):	
Start Date:	End Date:	Expiration Date:	Frequency (how often):	Time:	
Dose:	Route: <input type="checkbox"/> Mouth <input type="checkbox"/> Injection <input type="checkbox"/> Inhalation <input type="checkbox"/> Ear <input type="checkbox"/> Eyes <input type="checkbox"/> Nose <input type="checkbox"/> Topical <input type="checkbox"/> Other: _____				
Reason for Medication:		Special Instructions:			

Please read the following statements and provide your initials as an acknowledgment:

- All medications must be in their newest original container with accurate labeling. _____
Initials
- Parent/Guardian is responsible for providing needed medication and maintaining the supply as needed. _____
Initials
- Parent/Guardian is responsible for picking up all unused medication by the last day of school. All medication left at the school will be discarded. _____
Initials
- Parent/Guardian accepts responsibility for notifying the school in writing of any changes to the student’s medication during the school year and after the date shown on this document. _____
Initials
- Any changes in administration from the prescription label or manufacturer’s directions must be signed by the student’s health care provider. _____
Initials

Parent/Guardian Authorization:

I verify the above health information is accurate and complete, and I understand it is my responsibility to promptly notify the school office or consulting nurse in writing of any changes to this information.

This authorization applies only to the medication listed above and the duration of treatment and school year.

I authorize exchange of information between Bend-La Pine Schools personnel and my student’s medical provider.

Parent/Guardian Signature: _____ Date: _____

Parent Guardian Name (Printed): _____

Medical Provider Approval – Required* for any deviation from prescription label or manufacturer directions

Medical Provider signature: _____ Date: _____

Address: _____ Phone: _____

* Medical Provider Approval may be provided in a separate document (e.g. a doctor’s note), which must be attached to this form.
Updated 12-04-2025

Medication Administration Log

(For personnel who do *not* have Synergy medication access)

Date	Time	Dose	Initials

Date	Time	Dose	Initials

Name (Printed):	Initials:	Name (Printed):	Initials:
Name (Printed):	Initials:	Name (Printed):	Initials:

Unit Adjustment Documentation

Date	Time	Medication count PRIOR to adjustment (For new medication, write "New")	Amount of medication checked in/out (specify quantity)	Total medication count at school AFTER adjustment	Parent/Guardian signature	Staff signature

Medication Disposal Documentation

Date	Time	Amount Discarded	Staff Signature	Witness Signature