



AUTHORIZATION FOR MEDICATION ADMINISTRATION BY DESIGNATED SCHOOL PERSONNEL

Student name: _____ DOB: _____

School: _____ Grade: _____

I give school personnel permission to administer this medication per the following instructions:

Medication: _____ Start Date: _____ End Date: _____

Dose (strength/how much): _____ Non Prescription _____ Prescription

Frequency (how often): _____ Time of day for meds at school: _____

Pharmacy Name: _____

Route (circle one): Mouth Ear Eye Nose Skin Prescription Number (if applicable): _____

Prescriber Name (if applicable): _____ Prescriber Phone (if applicable): _____

Reason for Medication: _____

Special Instructions:

ALL MEDICATION MUST BE IN ITS UNEXPIRED, 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, and that all staff-administered medications are to be brought to and from school by a parent/guardian. 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 Signature: _____ Date: _____

Parent/Guardian Phone Number: _____

Prescriber Direction:

The health care provider's signature is required **ONLY** for prescription medication (**may be in the form of a current RX label**).

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

____ Instructions from the parent are accurate

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

Special instructions, including adverse reactions and actions required:

Prescriber's Name (please print/stamp): _____

Prescriber's Signature: _____ Date: _____

Clinic Name and Address: _____ Phone: _____