Tigard-Tualatin School District 23J Medication Administration Form

This order is valid only in Tigard-Tualatin School District for the current school year or until discontinued by physician

Student Name:	School:
Birthdate:	Grade/Teacher's Name:
Parent/Guardian Name and Phone:	Parent/Guardian Name and Phone:

Parent/Guardian: Please read the following statements and provide your initials as an approval or acknowledgment. Parent Initial Here

1. All medication must be in its original container with accurate labeling and student's name affixed. If medication is by prescription, the current prescription label must be attached, including the student's name, medication name, dose, time/frequency of administration.	
2. Parent/guardian is responsible for providing needed medication and maintaining the supply, and for verifying the contents of the medication. If the medication should be half doses, pills must be cut by parents or the issuing pharmacy.	
3. 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.	
4. Parent/guardian accepts responsibility of notifying the District Nurse or the school's main office/health room staff in writing of any changes to the student's medication during the school year. Changes to the prescription label or container directions must be in writing from the healthcare provider. NO VERBAL CHANGES ARE ALLOWED.	
5. Medication must be medically necessary for the student to take while in school.	

Medication Name:	Medication Type: Prescription ____ Non-prescription_____
Date Dropped Off At School:	Date to be Discontinued:
Time Medication To Be Given:	Dose To Be Given (no abbreviations):
Route: Mouth____ Ear____ Eye _____ Nose____ Skin___	Injection ___ Other _____
Reason For Medication:	Special Instructions:

Parent/Guardian Signature and Authorization

I verify that the above health information is accurate and complete, and I understand that it is my responsibility to notify the school office in writing promptly of changes to this information. This authorization applies only to the medication listed above and for the duration of treatment or school year.

This authorization provides permission to exchange information regarding the medication, as necessary, between the District Nurse, school staff and/or my student's health provider.

Parent/Guardian Signature: _____ Date: _____

Office Staff only: ☐ **Notify RN** ☐ **Put hard copy in binder**

Nurse only: ☐ **Reviewed and approved** ☐ **Medication to go on Field Trip** ☐ **Note in Synergy**

This medication was disposed by the following method: _____ Medication disposal date: _____

Reason: _____ Medication disposed by (signature): _____