

**HILLSBORO SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM**

Student: _____ Birth Date: _____ SID: _____ School: _____ Grade: _____

PLEASE FILL OUT COMPLETELY FOR ALL MEDICATIONS

*Over the Counter (OTC) Medication

Name of Medication: _____ Prescription Number or OTC*: _____

Strength of Medication: _____ Amount to be Given: _____ Medication Expiration Date: _____

Hours Between Doses: _____ Time Given at School: _____ Given at Home? Yes / No Time: _____

Amount in Container: _____ Staff Initials: _____ -OR- Double Initials for Controlled Substances Count: 1. _____ 2. _____

Directions: _____

Special Instructions: _____

Student to Self-Carry Medication? Yes: _____ No: _____ (Must have completed Self-Administration form and District Nurse permission.)

Medication Discontinue Date is the End of the School Year? Yes: _____ -OR- No: _____ When? _____

Provider's Name: _____ Provider's Phone Number: _____

RECOMMENDED: Guardian to provide all necessary supplies, pre-cut pills if needed, and limit controlled substances to one month supply.

I hereby request and authorize school staff to give this medication in accordance with the instructions provided on the prescription label or over the counter 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 Parent/Guardians sheet. **I also authorize the release and exchange of information with the Oregon licensed medical professional/provider regarding this medication.**

Guardian Name (Print): _____ Phone: _____

Guardian Signature: _____ Date: _____

REFILL INFORMATION:

Date: _____ Prescription Number: _____ Exp. Date: _____ Guardian Signature: _____

Count: _____ Staff Initials: _____ -OR- Double Initials for Controlled Substances Count: 1. _____ 2. _____

Date: _____ Prescription Number: _____ Exp. Date: _____ Guardian Signature: _____

Count: _____ Staff Initials: _____ -OR- Double Initials for Controlled Substances Count: 1. _____ 2. _____

Date: _____ Prescription Number: _____ Exp. Date: _____ Guardian Signature: _____

Count: _____ Staff Initials: _____ -OR- Double Initials for Controlled Substances Count: 1. _____ 2. _____

Date: _____ Prescription Number: _____ Exp. Date: _____ Guardian Signature: _____

Count: _____ Staff Initials: _____ -OR- Double Initials for Controlled Substances Count: 1. _____ 2. _____

DISCONTINUE MEDICATION:(Any changes to the medication *dosage* or *directions* require a NEW medication authorization and medication administration record.)

Date: _____ Count Returned to Guardian: _____ Staff Initials: _____ Guardian Signature: _____

STAFF PRINTED NAME / INITIALS:

_____ / _____	_____ / _____
_____ / _____	_____ / _____

MEDICATION REVIEW:

District Nurse Signature: _____ Date: _____