Authorization for Medication Administration by School Personnel

Student Name: ______________________________ DOB: ______________ Grade: ____

School Name: ______________________________ Teacher: ______________________

I am giving school personnel permission to administer the following medication to my child (Complete all underlined sections):

Medication Name:	Check One:
Dose (amount; for example, 5 mg., **not** 1 pill)	☐ Prescription - Requires physician direction (see below[1]) ☐ Nonprescription – must follow manufacturer's recommended dosing guidelines, otherwise requires prescription
Method of administration **(circle one)**: By: ☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin ☐ Inhalation	☐ Other (Describe)
Time of day to be given at school:	
Duration: start date end date	Special Instructions:
Reason for Medication:	

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ALL MEDICATION MUST BE IN THE MOST RECENT ORIGINAL CONTAINER WITH AN ACCURATE LABEL, AND MUST NOT BE EXPIRED. TABLETS REQUIRING CUTTING ARE TO BE CUT BY THE PARENT OR PHARMACIST BEFORE BEING BROUGHT TO SCHOOL. LIQUID MEDICATION REQUIRES A DOSAGE SPOON/CUP (AVAILABLE AT YOUR PHARMACY). MEDICATION THAT MUST BE CRUSHED REQUIRES A PILL CRUSHER (AVAILABLE AT YOUR PHARMACY) AND A SUBSTANCE TO MIX POWDER INTO (TO BE PROVIDED BY PARENT).

PRESCRIPTIONS MUST BE WRITTEN BY AN OREGON-APPROVED PRESCRIBER, AND HAVE A PHARMACY LABEL THAT INCLUDES[1]:

- Student name
- Medication name
- Dose
- Time/frequency of administration

______________________________ ______________________________

Oregon-licensed[1] healthcare prescriber's name   Phone number

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I understand: I am responsible to provide this medication and maintain the supply as needed; to notify the school in writing of any changes in the medication or prescriber; to pick up all unused medication by the last day of school (or it will be destroyed). This authorization is valid only until the end of this school year and applies only to the medication above. Parent signature below **authorizes an exchange of information**, as necessary, between the school nurse, necessary school personnel, or the student's healthcare provider.

Parent/Guardian/Student Signature: ______________________________ Date: ______________

[1] **Required in writing or on pharmacy label for all prescription medications per OAR 581-021-0037**

MEDICATION AT SCHOOL

When it is necessary for students to take medication at school, the procedure outlined below must be followed:

1. The "Authorization for Medication Administration" form must be filled out on a yearly basis if medication is to be dispensed.
2. A parent MUST deliver the medication (prescription and non-prescription) to the office. Children are not permitted to transport any medication to or from school.
3. Directions for dispensing the medication must accompany the medication (prescription and non-prescription).
4. A physician's written authorization must accompany the medication. (A prescription label will be considered to meet this requirement.)
5. The medication (prescription and non-prescription) must be in the original container and labeled with the child's name.
6. The medication will be secured in a safe place and dispensed by designated school personnel. Accurate records will be maintained.
7. It is the responsibility of the student to report to the office to take their medication.
8. Parents may come to school and administer medication as needed. Written authorization from a physician is not necessary if the parent dispensed the medication.
9. Medication not picked up by the parent within five (5) school days of the end of the medication period or at the end of the school year, whichever comes first, will be disposed of by district.