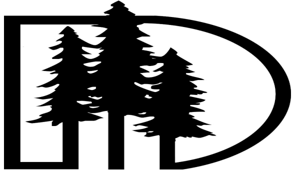

David Douglas School District

Authorization for Medication Administration by School Personnel

Complete and Return to School

To:____of____
(Principal) (School Name)

Student Name:____________________DOB_________Grade________Teacher________________________________

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

Medication's Name: Dose (prescribed amount, e.g . 5 mg., **not** 1 pill): *Tablets requiring cutting should be cut by the parent before being brought to school. Liquid medication requires dosage spoons, available from your pharmacist to be supplied by parent.* Route: (**circle one**) By: Mouth Ear Eye Nose Skin Inhalation Time of day to be given at school (e.g. 11 a.m., - ***not*** mid day) ____ (Write in actual time) Duration: Start date: ____________ End Date: ________ Reason for Medication: Special Instructions: ☐ Please allow my child to self-administer this medication. (Refer to district policy on self-medication). *Requires self-medication agreement form to be signed by parent, school administrator, and if prescription, consent of physician.[1] (See below).*	Check One: ☐ Non prescription ☐ Prescription Rx number **ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.** **PRESCRIPTIONS MUST BE WRITTEN BY OREGON-LICENSED PHYSICIANS.[1]** ☐ Other (Describe)

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 discarded); this authorization is **valid no longer than one year** from this date and applies only to the medication above; this **authorizes an information exchange**, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

Parent/Guardian Signature:______________________________Phone: ____________________Date:________________
(*This authorization applies only to the medication listed above and for the duration of treatment or school year). This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.*

OREGON LICENSED PHYSICIAN DIRECTION[1]

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

☐ I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.

☐ Please allow this student to carry and self-administer this medication. (Must be allowed by school district policy. Student must be developmentally and behaviorally able to self-administer)

☐ Special instructions including adverse reactions and action required: ____

____

____ ____
Oregon-Licensed[1] Physician's Name (please print/stamp) Address

____ __________________________ ____________________
Oregon-Licensed[1] Physician's Name (please print/stamp) Phone # Effective Date

3/2010 rev.