Authorization for Medication Administration by School Personnel

School Name Grade Teacher

Student Name DOB

I am giving school personnel permission to administer medications to my child per the following: (Parent or Oregon-Licensed Provider, please complete.)

Medication Name:

Dose (how much):

Frequency (how often): ☐ Every Day **OR** ☐ As Needed

By: ☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin

Time:

Duration: Start Date: End Date:

Special Instructions:

Parent Name: Phone number:

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded. All prescriptions for severe allergies and asthma (example: epi-pens and inhalers) must also include a written treatment plan from an Oregon-licensed provider. All prescription medications must be prescribed by an Oregon-licensed provider.

Parent / Guardian Signature _____ Date_____

(This authorization applies only to the medication listed above and for the duration of the treatment during the 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.)