## Authorization for Medication Administration by Designated School Personnel

Student's name:_____ Birthdate:_____ Grade:____
I give school personnel permission to administer this medication per the following instructions:
One medication per form. Please complete entire form.

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Medication:_____ Start Date:_____ End Date:_____

Dose:_____ _____Non Prescription

Frequency:_____Everyday _____As needed _____Prescription

Time:_____ _____ OTC non-FDA approved

Route: (circle one):
Mouth Ear Eye Nose Skin

Prescriber Name: _____

Licensed in Oregon: _____yes _____no

Reason for Medication:

***All prescription and non-FDA approved medications must be prescribed by an Oregon licensed provider.***

Special Instructions:

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I understand I am responsible to provide this medication and maintain the supply as needed. All medication must be provided from home and must be in its original, labeled and unexpired container. All medications for life threatening allergies, asthma, seizures or any other condition requiring a rescue medication must also have a written treatment plan signed by an Oregon licensed provider. I understand that I am responsible to notify the school in writing of any medication changes, and that all staff-administered medications are to be brought to and from school by a parent/guardian or student when allowed. All unused medication must be picked up by the last day of school. I understand that any medication left at school will be discarded. (OAR 581-021-0037)

**Parent/Guardian Signature:_____ Date:_____**

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**Prescriber Direction**

(Required in writing or on pharmacy label for all prescription and non-FDA approved medications)

_____ I have prescribed the above medication for the student whose name appears at the top of the form.
_____ Instructions from the parent are accurate
_____ Please allow this student to carry and self-administer this medication. Student must be developmentally and behaviorally able to self-administer.
_____ I certify that this medication is necessary for the student to remain at school.
_____ Special instructions including adverse reactions and action required:_____
_____

Prescriber name (print/stamp):_____ Clinic phone:_____

**Oregon licensed prescriber signature: _____Date:_____**

Update: 4-2020