OREGON CITY SCHOOL DISTRICT - DISTRICT HEALTH SERVICES
AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL

To:_____ of:_____
(Principal) (School)

Student Name:_____D.O.B.:_____Teacher/Grade:_____

All medication MUST be in the original labeled container.

I am giving school personnel permission to administer medications to my child per the following directions:

To be completed by Parent/Guardian or Physician:

Medication:_____ ☐ Non-Prescription

Dosage (how much):_____ ☐ Prescription RX #:_____

Frequency (how often):_____ ☐ Please allow my child to self-administer (see below)

Route/Delivery (circle method): Mouth / Ear / Eye / Nose / Skin

Time(s):_____ Start Date:_____End Date:_____

Reason for medication:_____

- Physician's signature allowing self administration **may be required**. Please see lower portion of form.
- **Parental/Guardian recommendations** for dosage, age and frequency of non-prescription medications MAY NEVER EXCEED manufacturer's recommendations.

SPECIAL INSTRUCTIONS for emergency <u>asthma medicine</u> or <u>epinephrine</u> ONLY:

☐ Parent/Guardian has been asked to provide back-up medication for emergency use at school (per OCSD policy JHCD-AR)

☐ Back-up medication provided by parent/guardian will be located:_____

I understand and agree as the Parent/Guardian that I am responsible for bringing my child's medication to school and maintaining the supply as needed. I understand and agree that I am responsible for notifying the school of any changes in writing. I understand and agree that I am to notify the school of any doses that have been given to my child prior to the school day in order to avoid over-dosing/medicating my child.

Parent/Guardian Signature:_____Date:_____
This authorization applies only to the medication listed above and for the duration of treatment or school year. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded. This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health care provider.

PHYSICIAN'S DIRECTION / PHYSICIAN'S SIGNATURE

I have prescribed the above medication for the student whose name appears at the top of this form. This student has been instructed on the proper use of the prescription medication and is capable of self-administering that medication. Instructions indicated in the box above are accurate.

Special instructions including potential adverse reactions are:_____

_____ _____
Physician's Name Office Address

_____ _____ _____
Physician's signature Phone Number Effective Date