McMinnville School District #40

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student's name:_____ Birthdate: _____ Grade: _____

I am giving school personnel permission to administer medication(s) to my child per the following instructions:
Parent or Physician must complete: (Please do not skip any questions)

Medication: _____

Dose (strength/how much): _____

Frequency (how often): _____

Time of day for meds at school: _____

Route (circle one):
Mouth Ear Eye Nose Skin

Start date: _____ End date: _____

Reason for medication:

Special Instructions:

_____ Non Prescription

____ Prescription RX number: _____

Pharmacy Name: _____

____ Please allow my child to self-administer this medication. *Requires self-medication agreement form to be signed by parent, school administrator, and if prescription, consent of physician. (see below)*

ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINER WITH AN ACCURATE LABEL

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 contained in its original-labeled container. 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 or guardian.** Parents are required to pick up all unused medication by the last day of school. I understand that any medication left at school will be discarded.

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

PHYSICIAN DIRECTION
(Required in writing or on pharmacy label for all prescription medications)

____ I have prescribed the above medication for the student whose name appears at the top of this 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.)
____ Special instructions including adverse reactions and action required: _____

_____

_____ _____
Physician's Name (please print/stamp) Clinic Name and Address

_____ _____ _____
Physician's Signature Phone Effective Date