Bethel School District #52
Eugene, Oregon 97402

Authorization for Medication Administration by School Personnel

Student Name_____DOB_____
Grade_____Teacher_____School_____

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

Medication name & strength:
_____

Dose: (how much)_____

Frequency: (how often)_____

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

Time:_____
Duration: Start date_____
End date_____

___Allow my child to self medicate
(must complete self-medication form)

Reason for medication:

☐ Description on label matches pills
☐ Medication counted

Health Room/Office Use Only
Daily Short Term Medication Only

Date_____Time_____Initial___
Date_____Time_____Initial___
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Initial: Staff Signature:
_____
_____
_____

Date_____Amount_____

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.

Parent/Guardian Signature_____Date_____
(This authorization applies only to the medication listed above and for the duration of treatment or school year). This also authorized an exchange of information, as necessary, between the school personnel, and/or my child's health care provider.

The following trusted adults have my permission to transport the above medication:

_____ , _____ , _____

Physician Direction

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

_____ _____
Physician's Name (please print/stamp) Physician's Signature Date