Eugene School District 4J
Authorization for Medication Administration by School Personnel
SCHOOL BOARD POLICY available on line: http://policy.osba.org/eugene and search for "medication"

Students Name_____ Birthdate_____

School Name_____ Grade_____

I am giving school personnel permission to administer medications to my child per the following:
Parent to complete separate form for each medication:

Medication: _____ _____ Non Prescription (*sin recta)*
Medicina
Dose (how much):_____ _____Prescription *(receta)* Rx number_____
Dosis Exp Date:_____

_____Please allow my child to self-administer this medication (refer to district medication policy)

Frequency (how often): _____
Frequencia
Route: (circle one)
By: Mouth Ear Eye Nose Skin
Boca oido ojo nariz piel

Time: _____
Hora
Duration: Start date_____ end date_____
Fechas para empezar y terminar
Reason for Medication: _____
La razon para la medicina
Special Instructions: _____

I understand I am responsible to provide this medication in the ***most current pharmacy container with accurate label*** *or* ***manufactured packaging*** *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 on the last day will be discarded****.*

Parent/Guardian Signature:_____Date:_____ Phone:_____
(This authorization applies only to medication listed above and for the duration of treatment or 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. Health care provider's name is:_____ and phone_____.

ADMINISTRATOR APPROVAL*
(when necessary for self administration of medication, see district policy)

Administrator Signature:_____Date:_____
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OREGON LICENSED PRESCRIBER DIRECTION
is required in writing or on pharmacy label for all prescription medications per OAR 581-021-0037
___ I have prescribed the above medication for the student whose name appears at the top of this form. Above instructions are accurate.

___Please allow this student to carry and self-administer this medication. (As allowed by school district policy, student must be able both developmentally and behaviorally able to self-administer and be responsible for the medication)

___Special instructions including adverse reactions and action required:_____
_____

_____ _____
OREGON LICENSED PRESCRIBER Name (please print or stamp) Address

_____ _____ _____
OREGON LICENSED PRESCRIBER SIGNATURE Phone Effective Date