

**Southern Oregon ESD
 STEPS PROGRAM
 Authorization for Medication Administration by School Personnel**

Student Name _____ Birthdate _____
 Parent/Guardian _____ Phone _____ Cell _____
 Physician Name _____ Phone _____

Instructions provided by your doctor are needed in order for your child to take prescription medication at school. This is obtained from the prescription label. Only medication in the original container with a prescription label will be accepted. All over-the-counter medication must be accompanied by parent's signature, complete instructions, and must be in the original container.

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

Parent please complete:

| | |
|---|--|
| <p>Medication: _____ Dose (how much) _____ Frequency (how often) _____ How given: (circle one) By: Mouth Ear Eye Nose Skin Time: _____ Duration: Start date _____ end date _____ Reason for Medication: _____ _____ _____ Special Instruction: (such as: give crushed in food or liquid) _____ _____ _____</p> | <p><input type="checkbox"/> Non-prescription <input type="checkbox"/> Prescription Rx number _____ <input type="checkbox"/> Possible medication side effects: _____ _____ _____</p> |
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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.

This authorization applies only to the 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.

Parent/Guardian Signature: _____ Date: _____