Southern Oregon ESD
Authorization for Medication Administration by School Personnel

NAAME:		DOB:
Parent/ Guardian:		
Phone #1:	Phone #2:	

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 permission to administer medications to my child per the following:

Parent please complete:

Medication: ______________________ Dose (how much): ______________________ Frequency (how often):	☐ Non-prescription ☐ Prescription RX number:
How given (X one) by: ☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin ☐ Gastric Button	☐ Possible medication side effects:
Time: ______________________	
Start Date: __________ End Date: __________	
Reason for Medication: ______________________	
Special Instruction: (such as: give crushed in food or liquid)	

- 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 care provider.

Parent/ Guardian Signature: ______________________________ Date: __________