SCIO SCHOOL DISTRICT

Authorization for the Administration of Medication by School RN or Delegated School Personnel

Student Name: _____

DOB:_____ **Grade:** _____ **School Year**: _____

ALL MEDICATIONS MUST BE IN ITS UNEXPIRED, ORIGINAL CONTAINER WITH ACCURATE LABEL

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

This medication is a: ☐ Prescription ☐ Non-Prescription

Medication Name: _____ Dose: _____

Frequency: _____ Time taken: _____

Route: *(by mouth, ear, eye, nose, skin, injectable*)* _____

*requires written Individualized Health Management Plan

Start Date: _____ End Date:_____

Medication Indication: _____

Special Instructions: _____

_____

I understand I am responsible to provide this medication in the original container, labeled and unexpired, and maintain supply as needed. I understand I am responsible to notify the school in writing of any changes. Prescription medication changes require written instructions from the prescribing provider. I release Scio School District from any legal responsibility involved in the dispensing of this medication. I am aware that all unused medication must be picked up by the last day of school and any medication left at school will be discarded. (OAR 581-021-0037)

Parent/Guardian Name _____

Parent/Guardian Signature _____ **Date** _____

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

STAFF USE ONLY

Physician Authorization-Prescription Medication ONLY

☐ **Prescription Label** ☐ **Letter** ☐ Fax

_____

(Signature of Verifier and Date)