La Salle Catholic College Prep

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY DESIGNATED SCHOOL PERSONNEL

Student's name:_____ Birthdate:_____ Grade: _____

I give school personnel permission to administer this medication per the following instructions: (Do not skip any questions)

Medication:_____

Dose (Strength/how much):_____

Frequency (how often):_____

Time of day for meds at school:_____

Route (circle one):
Mouth Ear Eye Nose Skin

Reason For Medication:

Special Instructions:

Start Date:_____ End Date:_____

_____Non Prescription

_____Prescription

Pharmacy Name:_____

Prescription Number (if applicable): _____

Prescriber Name (if applicable): _____

Prescriber Phone (if applicable): _____

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

I understand I am responsible to provide this medication and maintain the supply as needed. All medication must be provided from home and must be contained in its original, labeled and unexpired container. I understand that I am responsible to notify the school in writing of any medication changes, and that all staff-administered medications are to be brought to and from school by a parent/guardian or student when allowed. All unused medication must be picked up by the last day of school. I understand that any medication left at school will be discarded. (OAR 581-021-0037)

Parent/Guardian (or student) Signature: _____ Date: _____

PRESCRIBER DIRECTION

(Required in writing or on pharmacy label for all prescription medication and non-FDA approved medications)

____ I have prescribed the above medication for the student whose name appears on the top of the form

____ Instructions from the parent are accurate

____ Please allow this student to carry and self-administer this medication. (Student must be developmentally and behaviorally able to self-administer)

____ I certify that this medication is necessary for the student to remain in school

____ Special instructions including adverse reactions and action required:_____

_____ Prescriber's Name (please print/stamp)

_____ Clinic Name and Address

_____ Prescriber's signature

_____ Phone

_____ Effective Date