DOUGLAS
EDUCATION SERVICE DISTRICT
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AUTHORIZATION FOR MEDICATION ADMINISTRATION

School: _____

Student's name:_____ DOB:_____Grade:_____

I am giving school personnel permission to administer medication(s) to my child per the following instructions:
Parent/Guardian must complete: (Please do not skip any questions)

Medication: _____ _____Non Prescription

Dose (strength/how much): _____ Prescription RX number: _____

Frequency (how often): _____ Pharmacy Name: _____

Time of day for meds at school: _____

Please allow my child to self-administer this medication. *Requires self-medication agreement form to be signed by parent, school administrator, and if prescription, consent of physician.*

Route (circle one):
Mouth Ear Eye Nose Skin

Yes _____ No _____

Start date:_____End date: _____

Reason for medication:

Special Instructions:

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH AN ACCURATE LABEL

****The written instructions from the physician for the administration of the prescription medication to the student must include the following:**

- Name of student, name of medication, route, dosage, frequency of administration, and other special instructions. This can be a prescription label if complete.

Important information for parents/guardians:

- 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 container.
- Please include liquid measuring device. A teaspoon or tablespoon *cannot* be used for dispensing medication. If medication is to be cut in half, parents must do so before bringing to school. If medication is to be crushed, parents please provide crusher.
- I understand that I am responsible to notify the school in writing of any medication changes, and that all medications are to be brought to and from school by a parent or guardian.
- Parents are required to pick up all unused medication by the last day of school. I understand that any medication left at school will be discarded.

Parent/Guardian Signature _____ **Date:** _____

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

1871 NE STEPHENS STREET | ROSEBURG, OR 97470 | OFFICE 541.440.4777 | FAX 541.440.4771
www.douglasesd.k12.or.us

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SELF-MEDICATION AGREEMENT

Students who are developmentally and/or behaviorally able, will be allowed to self-administer prescription and nonprescription medication, subject to the following:

1. A permission form must be submitted for all self-medication of prescription and nonprescription medication.
   - Self-medication of prescription medication requires permission from parent, school administrator and physician. Physician consent is to be included on the prescription label or on the medication consent form.
   - Self-administration of non-prescription medication requires permission from parent and school administrator.
2. All prescription and nonprescription medication must be kept in its appropriately labeled, original container as follows:
   - Prescription labels must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions.
3. Physician's consent for self-administration must either be on the prescription label or on this form.
4. Sharing and/or borrowing of medication with another student is strictly prohibited.
5. Permission to self-medicate may be revoked if the student violates school district policy governing administration of non-injectable medication and/or these regulations. Additionally, the student may be subject to discipline, up to and including expulsion, as appropriate if the self-medication policy is violated.

Student Name:_____

I have read and agree to the above criteria and give permission for my child to self-administer:

Name of medication: _____

Parent/Guardian Signature: _____ Date: _____

(My signature authorizes an exchange or information as necessary between the school and my child's health provider for the purpose of information relating to this medication.)

I agree to comply with the above criteria:

Student Signature:_____ Date: _____

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

Physician Signature: _____ Date:_____
(Required for prescription medications)

____ This student may carry and self-administer this medication as prescribed

____ This student may self-administer this medication as prescribed, but the medication will be kept in the office.

School Administrator's Signature:_____Date: _____

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