Authorization for Medication Administration

Medication administered at school must be necessary for the student to remain in school and may only be administered exactly as prescribed or as designated on the commercial container [OAR 581-021-0037]. Written parent/guardian authorization is a requirement for medication administration in the school setting. Unexpired medication must be brought to school by the parent/guardian, in the original container, with an intact prescription or commercial label. Parent/guardian must pick the medication up at the end of the school year, or it will be disposed of after the last day of school.

Right Student	**Student's Name:**	**Date of Birth:**
	School:	**Grade:**
Right Medication	**Name of Medication:**	
Right Dose	**Dose of Medication** (*please list the full dosage such as 10mg – do not put how many pills*)**:**	
Right Reason	**Reason for Medication (why is medication needed):**	
Right Route	**Route of Medication**: ☐Oral (by mouth) ☐Cutaneous (skin) ☐Inhaled ☐Otic (ears) ☐Ocular (eyes) ☐Nasal (nose) ☐Sublingual (under the tongue) ☐Buccal (in the cheek) ☐Other: ☐Transdermal (patch)	
Right Time	**Daily Medication - time to be given**:	
	Frequency of Medication (how often):	**Duration of Medication (discontinue date):**
	☐**As needed Medication "PRN": Conditions under which medication should be administered:**	
Prescription	**Consistent with:** ☐Pharmacy Prescription Label ☐Doctor's Written Order	
Non-prescription	**Consistent with:** ☐Commercially Prepared Medication Label	
Self-Medication	☐Please allow my student to carry and/or self-administer this medication (Complete the S*tudent Self-Medication Agreement* on the back of this form).	
Authorization	*I hereby grant my permission to the school district and designated trained employees to administer the above medication to my child during the school day and during school sponsored activities. I understand it is my responsibility to refill the medication, and to provide the school with a new signed medication authorization and written update of any medication changes before any updates can go into effect*.	
	Parent/Guardian Signature:	Date:
School Staff (Initial)	_____ Form completed/correct _____ MAR (Downtime Form) _____ Check in/out form _____ Input into EHR _____ Medication received & Inventory Complete _____ Self Carry Completed if applicable	
Prescription	**Consistent with:** ☐Pharmacy Prescription Label ☐Doctor's Written Order	
Non-prescription	**Consistent with:** ☐Commercially Prepared Medication Label	

Student Self-Medication Agreement

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

1. This Self-Medication Agreement form must be submitted for all self-medication
    - Self-administration of non-prescription medication requires this form and permission from a school administrator. Self-administration of non-FDA approved medication must also include a written order from a prescriber.
    - Self-administration of prescription medication requires this form, and permission from a school administrator and either a RN practicing in the school setting, or a prescriber.
2. All 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. Sharing and/or borrowing of medication with another student is strictly prohibited
4. Permission to self-medicate may be revoked if the student violates school district policy governing administration of 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.

Name of Medication:

STUDENT: I have read and agreed to the above criteria which are required for me to carry and administer my own medication at school.

Student Signature: **Date:**

PARENT/GUARDIAN:

- I agree that the student is behaviorally and developmentally capable of carrying and administering their own medication at school.
- I agree to the above criteria, understanding that if my student is self-carrying and self-administering their medication that staff will *not* be monitoring administration, and I allow my student to carry and/or administer their own medication at school as indicated below.
- I have completed the Authorization for Medication Administration Form.

Parent Signature: **Date:**

SCHOOL ADMINISTRATOR: I agree that the student is behaviorally and developmentally capable of carrying and administering their own medication at school.

Administrator Signature: **Date:**

PRESCRIBER OR SCHOOL NURSE: (Prescription Medications ONLY)

- I have reviewed the above information and believe this medication is appropriate for the student to self-carry and administer.

Prescriber or RN Signature: **Date:**