Authorization for Medication Administration

Student: ______________________________

DOB: ______________ Weight: ____________ Grade: ____________

All medication MUST be in the ORIGINAL CONTAINER

One medication per form • Not expired

Prescriptions must be written by Oregon-licensed Physician

Fill out completely. Please print.

❶ Medication name: ______________________________

❷ Select type: ❍ non-prescription ❍ prescription (if missing RX label another form is required)

❸ TOTAL dose to administer*: ____________
Every ____________ hours

❹ Method of administration: ❍ mouth ❍ inhalation ❍ skin ❍ ear ❍ eye ❍ nose

❺ Time of day: ❍ as needed ❍ specific time____________ (ex. 10:00 am)

❻ Duration: ❍ as needed throughout school year
❍ start date: ______________ end date: ______________

❼ Reason for medication: ❍ pain ❍ allergies ❍ other (please describe): ____________
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* **Tablets requiring cutting** should be cut by the parent before being brought to school.
Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent.

I UNDERSTAND: I am responsible to provide this medication and maintain the supply as needed; to notify the school in writing of any changes in the medication or prescriber; to pick up all unused medication by the last day of school (or it will be discarded); this authorization is valid no longer than one year from this date and applies only to the medication above; this authorizes an information exchange, as necessary, between the teacher, medically-certified staff, and/or my child's health provider. Upon review of instructions provided on this form, St. Stephen's Academy reserves the right to decline acceptance of a parent or legal guardian's authorization for us to administer medication.

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Parent Signature Date