Eugene School District 4J
Authorization for Medication Administration by School Personnel
SCHOOL BOARD POLICY available on line: http://policy.osba.org/eugene and search for "medication"

Students Name_____ Birthdate_____

School Name_____ Grade_____

I am giving school personnel permission to administer medications to my child per the following:
Parent to complete separate form for each medication:

Medication: _____
Medicina
Dose (how much):_____
Dosis

☐ Non Prescription

☐ Prescription Rx number_____
Ex Date:_____

☐ Please allow my child to self-administer this medication (refer to district policy on self-medication*).

Frequency (how often): _____
Frequencia
Route: (circle one)
By: Mouth Ear Eye Nose Skin
Boca oido ojo nariz piel

Time: _____
Hora
Duration: Start date_____ end date_____
Fechas para empezar y terminar
Reason for Medication: _____
La razon para la medicina
Special Instructions: _____

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*I understand I am responsible to provide this medication in the **pharmacy container** or **manufactured packaging** and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to* **pick up all unused medication** *by the last day of school. All medication left at the school will be discarded.*

Parent/Guardian Signature:_____Date:_____Phone:_____
(This authorization applies only to medication listed above and for the duration of treatment or school year). This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider. Health care provider's name is:_____

ADMINISTRATOR APPROVAL*
(for K-8th grade self administration of medication)

Administrator Signature:_____Date:_____

PHYSICIAN DIRECTION
(required on pharmacy label OR in writing for all prescription medications, also required for any aspirin containing products)

I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate._____
Special instructions including adverse reactions and action required:_____

_____

_____ _____ _____
(Physician's Signature) (Phone number) (Effective Date)

Revised 5/6/08
Form # 132

AS NEEDED MEDICATION ADMINISTRATION RECORD

Revised 10-17-13

Name of student_____ Date of birth_____

Medication & Directions	Dose	Date & time given	Administered by