Philomath Public Schools

Benton County School District 17J, 1620 Applegate Street, Philomath OR 97370 (541) 929-3169

Authorization for Medication Administration by School Personnel

Parent or Physician to complete:

Student name: _____ DOB: _____ Grade: _____

Medication: _____

Circle one: Non Prescription (OTC) Prescription (# count: _____) Initials _____, _____

Dose (how much): _____

Frequency (how often): _____

Route (circle one): Mouth Ear Eye Nose Skin

Time medication is to be administered: _____

Duration: Start date: _____ End date: _____

Reason for medication:

_____

Special Instructions: _____

Physician Signature (if indicated)

_____

ALL MEDICATION MUST BE IN ORIGINAL CONTAINER

*If your student will be self-medicating during the school day and/or school event, please fill out the "Self-Medication" permission form and agreement.

____Please send this medication on field trips that overlap dosage times.

I understand I am responsible to provide this medication 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 date of school. All medication left at the school will be discarded.

_____

Parent /Guardian signature Date

This authorization applies only to the 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.