



South Lane School District

P.O. Box 218
455 Adams Ave.
Cottage Grove, OR 97424

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Authorization for Medication Administration by School Personnel

Student Name: _____ of _____
(School Name)

DOB: _____ Grade: _____ Teacher: _____

I am giving school personnel permission to administer medications to my child per the following:
Parent please complete:

Medication: _____

Non Prescription (non-alcohol content)

Dose: (how much) _____

Prescription RX Number

Frequency (how often) _____

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

Route: (circle one)

By: Mouth Ear Eye Nose Skin

Time: _____

Duration: Start date: _____ end date _____

Reason for Medication:

Note: to self administer non-prescription medication, the non prescription medicine must be essential so that the student may remain in school.

Special Instructions:

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 day of school. All medication left at the school will be discarded.

➡ PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Physician Direction

(required in writing on pharmacy label for all prescription medications)

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 – see attached.

Physician's Name (please print/stamp)

Address

Zip code

Physician's Signature

Phone #

Effective date