South Lane School District

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

PHONE(541) 942-3381
FAX (541)942-8886
FAX (541) 942-8098

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:_____

Dose: (how much)_____

Frequency (how often)_____

Route: (circle one)
By: Mouth Ear Eye Nose Skin

Time: _____

Reason for Medication:
_____

Special Instructions:
_____

☐ Non Prescription (non-alcohol content)

☐ Prescription RX Number

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

Duration: Start date:_____end date_____

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

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