



South Lane School District

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Authorization for Medication Administration by School Personnel

Student Name: _____ of _____

DOB: _____ Grade: _____ (School Name) _____
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 _____

Self-Medication Agreement

Students who are developmentally and/or behaviorally able, will be allowed to self-administer prescription and non-prescription medication, subject to the following:

1. A permission form must be submitted for all self-medication of all prescription and non-prescription medication.
 - a. Self administration of prescription medication requires permission from parent, school administrator and physician. Physician consent is to be included on the prescription label or on the medication consent form.
 - b. Self administration of non-prescription medication requires permission from parent and school administrator.
2. All prescription and non-prescription medication must be kept in its appropriately labeled, original container, as follows:
 - Prescription labels must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions. Physicians consent for self administration is to be on the label or on the medication consent form.
 - Non-prescription medication must have the student's name affixed to the original container.
3. The student may have in his/her possession only the amount of medication needed for that school day.
4. Sharing and/or borrowing of medication with another student is strictly prohibited.
5. Permission to self-medicate may be revoked if the student violates school district policy governing administration of non-injectable medication and/or these regulations.

I have read and agree to the above criteria and give permission for my child to carry

Name of Prescription

Date

Parent Signature

Date

Student Signature

Date

This student may carry and self administer this medication as prescribed.

School Administrator/Designee

Date