Corvallis School District 509J

MEDICATION AUTHORIZATION AND ADMINISTRATION FORM

Student Name: ______________________________________ DOB: ________________ Grade: _____

School: ______________________________________ Teacher/Counselor:____________________

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

PARENT OR PHYSICIAN PLEASE COMPLETE

Medication: _________________________________

Dosage (how much): _____________________________

Frequency (how often): ___________________________

Expiration date of medication:_____________________

❒ Non prescription

❒ Prescription Rx #:__________________

❒ Please allow my child to self-administer this medication. (Complete Self-Medication form. Refer to district policy on self-medication).

Route: ❒ Mouth ❒ Ear ❒ Eye ❒ Nose ❒ Skin

Duration: Start Date________________ End Date ________________ Time of day: ____________________

Reason for Medication: ____

____

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: ____________________

(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 health care provider, appropriate school personnel, and/or my child's health provider.

MEDICATION SENT / RECEIVED

Amount Sent: ______ Amount Received: ______ Verifyer #1: ______________________ Date:_______

Amount Sent: ______ Amount Received: ______ Verifyer #2: ______________________ Date:_______