

PLEASE TAKE ATTACHED COPY OF SCHOOL BOARD POLICY
Eugene School District 4J
Authorization for Medication Administration by School Personnel

Students Name _____ Birthdate _____

School Name _____ Grade _____

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

Parent or Physician please complete:

Medication: _____
Medicina

Non Prescription

Dose (how much): _____
Dosis

Prescription Rx number _____

Ex Date: _____

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

Frequency (how often): _____
frecuencia

Route: (circle one)

By: Mouth Ear Eye Nose Skin
boca oido ojo nariz piel

Time: _____
Hora

Duration: Start date _____ end date _____
fechas para empezar y terminar este ano escolar

Reason for Medication:
la razon para la medicina

Special Instructions:

I understand I am responsible to provide this medication in the pharmacy container or manufactured packaging 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 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. Health care provider's name is: _____

ADMINISTRATOR APPROVAL*

(needed for self administration of medication)

Administrator Signature: _____ Date: _____

PHYSICIAN DIRECTION

(required in writing or on pharmacy label for all prescription medications, also required for any aspirin containing products)

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: _____

(Physician's Signature)

(Phone number)

(Effective Date)