



998 West A Street | Creswell, OR 97426

Nursing Office: (541) 895-6197

**Authorization for Medication Administration By School Personnel**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Teacher/ Grade: \_\_\_\_\_

**\*Please make sure these instructions match the prescription label and/or the manufacturer's instructions. \*Medication MUST match description on label.**

Medication: \_\_\_\_\_ Dose (how much?): \_\_\_\_\_

Frequency (how often?): \_\_\_\_\_ Route: \_\_\_\_\_

Time(s): \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_(Initial Here) I understand that I am responsible to provide this medication and maintain the supply as needed. It is the parent/guardian's responsibility to inform the school IN WRITING if any changes are made to medication instructions. This includes written instruction from parent/guardian and prescribers. A new pharmacy label needs to be provided to the school, if applicable. I understand I am required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

\_\_\_\_\_(Initial Here) I give my permission for the Creswell School District to obtain information from my child/childrens physician regarding his/her medication(s) for the current school year.

\_\_\_\_\_(Initial Here) I understand this information will not be shared with agencies or individuals other than those indicated. I further understand that my consent is voluntary and may be revoked at any time.

I give school personnel permission to administer medication(s) to my child for the following instructions during the \_\_\_\_/\_\_\_\_ school year.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Phone Number