CRESWELL
SCHOOL DISTRICT 40
ONE TEAM, ONE DREAM

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