West Linn-Wilsonville School District

Authorization for Medication Administration by School Personnel

Student Name:_____DOB:_____Grade:_____

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

Medication:_____

Expiration date of medication_____

Dose (how much):_____
Dosage to be administered at school cannot exceed manufacturer recommendation unless accompanied by a doctor's order.

Route: (circle one)
By: Mouth Ear Eye Nose Skin Inhalation Rectal Injection

Time to be given at school:_____

Reason for Medication: Check one:
_____Prolonged Seizure
_____Severe Allergic Reaction
_____Severe Hypoglycemic Reaction
_____Other (describe)_____

Begin Date_____ **End Date***_____

☐ Non-prescription

☐ Prescription

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.

Special Instructions:_____

Tablets requiring cutting will be cut by the parent before being send to school. Liquid medication requires dosage spoon to be supplied by parent

- 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 within 10 days of end date. All medication left at the school will be discarded.
- Parent must notify school of any doses of OTC medications given prior to the school day to avoid overmedicating the student (i.e. if student takes a pain reliever before coming to school)
- This authorization applies only to this above listed medication 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.

Parent/Guardian Signature:_____Date:_____

REV 05/14/2015