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:_____
(one medication per form)
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.
Inhalers? Please have pharmacy apply a label to the canister.

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

This medication needs to go on school field trips: YES_____ NO____

- 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 dose end date. All medication left after that time 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