# Authorization for Medication Administration
# by School Personnel

*Use one form for each medication.*

**Parent or Guardian MUST physically bring medication to school and return it home.**

**Name of Child:** _____

**Teacher:** _____ **Grade:** _____

**Medication Name:** _____

☐ **Non-prescription Medication** (MUST be in original container)

☐ **Prescription Medication** (MUST be in original labeled container) **Rx Number:** _____

**Dosage Amount:** _____

**Time(s) of Day to take Medication** (ex. 10 a.m., 1 p.m., after lunch, etc.): _____

**Start Date:** _____ **End Date:** _____

**Reason for Medication:** _____

**Special Instructions:** _____

- All prescription medication must be in its original, labeled container.
- Non-prescription medication must be kept in the original, labeled bottle or box, with the child's name clearly visible.
- The school is unable to administer medication sent to the school in unlabeled containers.
- Pills that must be cut need to be cut before they are brought to school.
- Medication must be brought to school and returned home by a parent or guardian.
- Parents or guardians are asked to pick up all unused medication by the last day of school; any medication remaining after June 30th will be discarded.

I hereby grant permission to the faculty and staff of All Saints School (601 NE Cesar E. Chavez. Blvd., Portland, Oregon 97232) to administer the above medication, in the stated dosage and times, to my child (named above). I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible for notifying the school in writing of any changes. This authorization applies only to the medication listed above and for the duration of treatment or school year. This authorizes an exchange of information, if necessary, between the school nurse, appropriate school personnel, and/or my child's health care provider.

**Parent/Guardian Signature** _____ **Date** _____

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***If you will be bringing a prescription medication that does not have the pharmacy label on it –***
please fill out the following and have your child's physician sign below.

_____ _____
Physician Name Address

_____ _____ _____
Physician Signature Date Phone