OREGON CITY SCHOOL DISTRICT – DISTRICT HEALTH SERVICES
AUTHORIZATION FOR MEDICATION ADMINSTRATION BY SCHOOL PERSONNEL

To:_____of:_____
(Principal) (School)

Student Name:_____DOB:_____Teacher/Grade:_____

All medication MUST be in the original labeled container

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

To be completed by Parent/Guardian or Physician:

Medication:_____ ☐ Non-prescription

Dosage (how much):_____ ☐ Prescription RX #:_____

Frequency (how often):_____ ☐ Please allow my child to self-administer (see below)

Route/Delivery (circle method): Mouth / Ear / Eye / Nose / Skin

Time(s):_____ Start Date:_____ End Date:_____

Reason for medication:_____

- **Physician's signature allowing self-administration may be required**. Please see lower portion of form.
- Parent/Guardian recommendations for dosage, age and frequency of non-prescription medications MAY NEVER EXCEED manufacturer's recommendations.

SPECIAL INSTUCTIONS for emergency <u>asthma medicine</u> or <u>epinephrine</u> ONLY:

☐ Parent/Guardian has been asked to provide back-up medication for emergency use at school (per OSCD policy JHCD-AR)

☐ Back-up medication provided by parent/guardian will be located:_____

I understand and agree as the Parent/Guardian that I am responsible for bringing my child's medication to school and maintaining the supply as needed. I understand and agree that I am responsible for notifying the school of any changes in writing. I understand and agree that I am to notify the school of any doses that have been given to my child prior to the school day in order to avoid over-dosing/medicating my child.

Parent/Guardian Signature:_____ Date:_____

This authorization applies only to the medication listed above and for the duration of treatment (or school year). Parents/Guardians are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded. This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health care provider(s).

PHYSICIAN'S DIRECTION / PHYSICIAN'S SIGNATURE

I have prescribed the above medication for the student whose name appears on the top of this form. This student has been instructed on the proper use of the prescription medication and is capable of self-administering that medication. Instructions indicated in the box above are accurate.

Special instructions including potential adverse reactions are:_____

Physician's Name | Office Address

Physician's Signature | Phone Number | Effective Date

HS 2.02 (01/15)

If self-medicating – this form to be used in conjunction with HS 2.03
"SELF-MEDICATION AGREEMENT"

Oregon City Public Schools
District Health – Special Services Department
1306 12th Street • Oregon City, Oregon 97045
503-785-8400 Office • 503-657-2505 Fax
Tina Moore, RN, District Nurse
Linda Previs, RN, District Nurse

SELF-MEDICATION AGREEMENT

Students, who are developmentally and behaviorally able, will be allowed to self-administer prescription and non-prescription medication without the assistance of trained school personnel, subject to the following:

1. A permission form must be submitted for self-medication of all prescription and non-prescription medication.
2. A physician may sign giving permission for a student to self-administer prescription medications.
3. **All prescription and non-prescription medication must be kept in its original/labeled container**, as follows:
    a. Prescription labels must specify the name of the student, name of the medication, dosage, delivery method and frequency or time of administration and any other special instructions.
    b. Non-prescription medication must have the student's name affixed to the original container.
4. The student may have in their possession only the amount of medication needed for that school day.
5. Sharing and borrowing of medication with/from another student is strictly prohibited.
6. Permission, to self-medicate, may be revoked if the student violates school district policies governing administration of non-injectable medication and/or these regulations. Additionally, students may be subject to discipline, up to and including expulsion, as appropriate.

Please note, under no circumstances, is a student allowed to carry or self-medicate what is considered a controlled substance/narcotic/pain killer. Please check with your school's health room or the District RN's for clarification.

I have read and agree to the above criteria and give permission for my child to carry their own medication.

_____ _____
Parent/Guardian Signature Date

I agree to comply with the above criteria.

_____ _____
Student Signature Date

HS 2.03 (01/15)

This form to be used in conjunction with HS 2.02
"Authorization for Medication Administration by School Personnel"