## **Authorization for Medication Administration by School Personnel**

Student Name:	DOB: Grade:
School Name: ACCESS Academy	DOB: Grade: Teacher:
I am giving school personnel permission to administer the following medication to my child (Complete all <u>underlined</u> sections):	
Medication Name:	Check One:
Dose (amount; for example, 5 mg., <b>not</b> 1 pill)	☐ Prescription - Requires physician direction (see below¹) ☐ Nonprescription – must follow manufacturer's recommended dosing guidelines, otherwise requires prescription
Method of administration (circle one):   By:	Other (Describe)
Time of day to be given at school:	
<u>Duration</u> : start date end date	Special Instructions:
Reason for Medication:	
**************************************	
<ul><li>Dose</li><li>Time/frequency of administration</li></ul>	
Oregon-licensed¹ healthcare prescriber's name  ***********************************	
Parent/Guardian/Student Signature:	

 $<sup>^{1}</sup>$  Required in writing or on pharmacy label for all prescription medications per OAR 581-021-0037