Knappa School District #4
Health Room- 503-458-6162 press #5, then ext 204
KHS 503-458-6162, press # 1

AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL
Over the counter and prescription

In accordance with Knappa School District policy, the following authorization is required for all medications administered at school.

Medication must be in its original container with the student's name. In the case of prescription medication, it must be accompanied by the physician's prescription **(a prescription label is sufficient).**
Medication is only administered at school if it is required that it be given during school hours.

Student's name _____
Birth Date _____
Parent contact # _____

Grade_____ Teacher_____

Name of medication_____

Dosage to be given_____ Time to be given_____

Route of administration (example- orally)_____

Date medication started at school _____
Date medication to be discontinued _____

Reason for medication _____

Any special instructions_____

I request and authorize that the school dispense this medication in accordance with the directions above, and following the directions of the prescribing provider. I understand that medication not picked up at the end of the school year will be destroyed.

_____ **Date**_____
Parent/Guardian signature

10/2014