

Harney County School District #3
**AUTHORIZATION FOR MEDICATION ADMINISTRATION
BY DESIGNATED SCHOOL PERSONNEL**

Student's name: _____ Birthdate: _____ Grade: _____

I give school personnel permission to administer this medication per the following instructions: (Do not skip any questions)

Medication: _____	Start Date: _____ End Date: _____
Dose (Strength/how much): _____	_____ Non Prescription
Frequency (how often): _____	_____ Prescription
Time of day for meds at school: _____	Pharmacy Name: _____
Route (circle one): Mouth Ear Eye Nose Skin	Prescription Number (if applicable): _____
Reason For Medication: _____	Prescriber Name (if applicable): _____
	Prescriber Phone (if applicable): _____

Special Instructions: _____

**ALL MEDICATION MUST BE IN ITS
UNEXPIRED, ORIGINAL CONTAINER
WITH ACCURATE LABEL**

I understand I am responsible to provide this medication and maintain the supply as needed. All medication must be provided from home and must be contained in its original, labeled and unexpired container. I understand that I am responsible to notify the school in writing of any medication changes, and that all staff-administered medications are to be brought to and from school by a parent/guardian or student when allowed. All unused medication must be picked up by the last day of school. I understand that any medication left at school will be discarded. (OAR 581-021-0037)

Parent/Guardian (or student) Signature: _____ Date: _____

PRESCRIBER DIRECTION

(Required in writing or on pharmacy label for all prescription medication and non-FDA approved medications)

_____ I have prescribed the above medication for the student whose name appears on the top of the form
_____ Instructions from the parent are accurate
_____ Please allow this student to carry and self-administer this medication. (Student must be developmentally and behaviorally able to self-administer)
_____ I certify that this medication is necessary for the student to remain in school
_____ Special instructions including adverse reactions and action required: _____

Prescriber's Name (please print/stamp)

Clinic Name and Address

Prescriber's signature

Phone

Effective Date