HOOD RIVER COUNTY SCHOOL DISTRICT
Excellence. Every student. Every day.

AUTHORIZATION FOR *MEDICATION ADMINISTRATION BY DESIGNATED SCHOOL PERSONNEL*

Student name:_____ **Birthdate**:_____ **Grade**:_____

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

Medication: _____

Dose (Strength/how much) :_____

Frequency (how often): _____

Time Medicine is Due at school:_____

Route (circle one): Mouth Ear Eye

Nose Injection Skin

Reason For Medication:

Additional Instructions:

Start Date:_____ End Date:_____

Prescription _____ Non-Prescription _____

Pharmacy Name: _____

Prescription # (if applicable): _____

Prescriber Name _____

Prescriber Phone # (if applicable): _____

ALL MEDICATION MUST BE UNEXPIRED, IN THE 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. 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 DIRECTIONS

(Only required if prescription medication does not have pharmacy label Or for 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 administer this medication. (The student must be at appropriate level of
*development and self-management behavior.)
*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)_____

Prescriber's Clinic Name and Phone Number_____

Prescriber's Signature_____ Date _____

HRCSD Medication Administration Log

Student:	DOB:	School:	Year:

Medication:	Dose:	Route/Instructions	Time:

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															

Signature:	Initials:

Key:

A: Absent ER: Error

NS: No School

R: Refused

O: No Medication Available

Medication Name:	Arrival Date:	Initial Count:	Initials: