SHERWOOD SCHOOL DISTRICT 88J

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL (FORM A)

To: _____ of _____
Principal *School Name*

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____

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

Parent or Medical Practitioner, please complete (one medication per form):

Name of Medication: _____

Dose (how much): _____

Frequency (how often): _____

Route (check one):

By: ☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin
Time: _____ AM _____ PM _____ Lunchtime

☐ Non-prescription

☐ Prescription

☐ Please allow my child to **self-administer** this medication. *(Parent must submit self-medication authorization form, form B.)* *Prescriptions require practitioner's written authorization, see below.

☐ Completed self-medication authorization form submitted, form B

Duration: Start date: _____ End date: _____

Reason for Medication:

Special Instructions: _____

☐ This medication must be taken along on field trips

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. *Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.*

Parent/Guardian Signature: _____ Date: _____

(This authorization applies only to the medication listed above and for the duration of treatment or school year.) This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

MEDICAL PRACTITIONER AUTHORIZATION

(Required in writing. Pharmacy label is acceptable in place of written physician order.)

I have prescribed the above medication for the student whose name appears at the top of this form. Instructions, as outlined above, are accurate.

☐ ***Self-administration: Student is behaviorally and developmentally able to carry and self-administer above medication, and has been instructed in the correct and responsible use of the medication. **REQUIRED** for self-carry of prescription medications.

☐ Special instructions (including adverse reactions) and action required:

_____

_____

_____ _____
Physician's Name (Please print/stamp) *Address*

_____
City, State, Zip Code

_____ _____ _____
Physician's Signature *Phone Number* *Effective Date*

SHERWOOD SCHOOL DISTRICT 88J
Office of Special Programs

PERMISSION FOR STUDENT TO SELF-MEDICATE (FORM B)

(SUBMIT WITH FORM A – "AUTHORIZATION FOR MEDICATION ADMINISTRATION")

Student Name: _____ Date of Birth: _____

School/Grade: _____ Teacher: _____

Students who are developmentally and behaviorally competent will be allowed to carry and self-administer prescription and non-prescription medications, subject to the following:

1. Self-administration of medication requires authorization from both parent and school administrator. NOTE: Prescription medications (including inhalers) require **additional** authorization from a medical practitioner that includes a written treatment plan for managing the student's asthma, diabetes and/or severe allergy, and acknowledgement that the student has been instructed in the correct and responsible use of the medication. The practitioner authorization to "self-medicate" may be stated on the prescription label OR written separately (on Form A – "Authorization for Medication Authorization").

2. The medication must be kept in the original, appropriately labeled container, as follows:
   - Non-prescription: must have student's name affixed to original container.
   - Prescription: Prescription label must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions.

3. The student may have only the amount of medication needed for one school day, except for medication packages with multiple doses, such as inhalers or "blister packs."

4. Sharing and/or borrowing of medication with another student is strictly prohibited.

5. Permission to self-medicate may be revoked if the student violates school district policy governing administration of medications and/or these regulations.

Please review the district policies governing administration of medication at our district website: Sherwood.k12.or.us under "School board" and then "Policies."

Parent/Guardian: Please complete the information in the box below:

		See form A or **RX label** for medication instructions including dose, route, time, frequency and special instructions.
Name of Medication	**Reason for medication**	**Medication instructions**
I give permission for my child to carry and self-medicate with the above medication, in accordance with the district policy. My child has been instructed in the correct and responsible use of this medication.		
Parent/Guardian Signature/ Date		Home Phone & Work Phone

Student Signature/Date (*I have reviewed and agreed to follow the district polices as stated above*)

Building Administration/Designee Signature/Date (*approval required*)