Dufur School District

Authorization for Medication Administration by School Personnel

Student Name:________________________DOB:________Grade:______Teacher:__________

I am giving school personnel permission to administer medication to my child per the following. (Parent or Physician please complete.)

Medication:_________________________

Dose: _______________________________

Frequency: __________________________

Route: (check one)

By: □Mouth □Ear □Eye □Nose □Skin

Time:_________________________________

Duration:

Start Date:________ End Date:_________

□Non Prescription

□Prescription, RX Number ____________

□Please allow my child to self-administer this medication. (Refer to District Policy on self-medication.)

Reason for Medication:

Special Instructions:

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. I understand that I am required to pick up all unused medication by the last day of the school year. All medications 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 the current 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.

***PHYSICIAN DIRECTION**

(Physician directions are required in writing or on pharmacy label for all prescription medications.)

I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate: _____________Special instructions, including adverse reactions and action required: ____________________________________

____

Physician's Name (please print or stamp) | Address

Physician's Signature | Phone Number | Effective Date

Dufur School District

Emergency Protocol Form

Student's Name:______________________ Parent(s):______________________
Birth Date:______________________ Address:______________________
Home Phone:______________________
Mother's Work Phone:______________________ Father's Work Phone:______________________

Alternate Emergency Contact #1
Name:______________________
Relationship:______________________
Address:______________________
____
Phone #s:______________________

Alternate Emergency Contact #2
Name:______________________
Relationship:______________________
Address:______________________
____
Phone #s:______________________

Diagnosis:
1.______________________
2.______________________
3.______________________

Weight:______________________
Allergies:______________________

Medication: (24 Hour Period)

	Name of Medication	Dosage	Time Given	Method Given
1.				
2.				
3.				
4.				
5.				

Major Heath Related Concerns:
1.______________________
2.______________________
3.______________________

Emergency Action:
1.______________________
2.______________________
3.______________________

Doctors:

	Name of Doctor	Address	Phone	Specialty
1.				
2.				
3.				

Date: ______________________ **Parent Signature:** ______________________
(Signature of parent/guardian indicates approval of emergency action.)