Dufur School District

Authorization for Medication Administration by Designated School Personnel

Student Name:_____DOB:_____ Grade:_____ Teacher: _____
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): _____	_____Non Prescription
Frequency (how often): _____	_____Prescription
Time of day:_____	Pharmacy Name:_____
Route: (check one)	Prescription Name:_____
□Mouth □Ear □Eye □Nose □Skin	Prescriber Name:_____
Reason For Medication:	Prescriber Phone:_____
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 medication 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 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:
_____

_____ Prescribers Name

_____ Clinic Name and Address

_____ Prescriber Signature

_____ Phone

_____ 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:_____

Alternate Emergency Contact #2
Name:_____
Relationship:_____
Address:_____
Phone:_____

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. _____
4. _____

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.)