All Saints School
Authorization for Medical Administration by School Personnel

(One form must be filled out for each separate medication to be administered)

Medication MUST be brought to school and returned home by a parent or guardian.

Name of Child_____

Teacher_____ **Grade**_____

Medication_____

☐ **Non-prescription Medication** (MUST be in original container)

☐ **Prescription Medication** (MUST be in original labeled container): **Rx Number**_____

Dosage Amount_____

Time(s) of Day to take Medication_____(ex. 10 a.m., 1 p.m., after lunch, etc.)

Start Date_____ **End Date**_____

Reason for Medication_____

Special Instructions_____

_____

All prescription medication must be in its original, labeled container. Non-prescription medication must be kept in the original, labeled bottle or box, with the child's name clearly visible. The school is unable to administer medication sent to the school in unlabeled containers. Pills that must be cut need to be cut before they are brought to school. Medication must be brought to school and returned home by a parent or guardian. Parents or guardians are asked to pick up all unused medication by the last day of school; any medication remaining after June 30th will be discarded.

I hereby grant permission to the faculty and staff of All Saints School (601 NE 39th, Portland, Oregon 97232) to administer the above medication, in the stated dosage and times, to my child (named above). I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible for notifying the school in writing of any changes. This authorization applies only to the medication listed above and for the duration of treatment or school year. This authorizes an exchange of information, if necessary, between the school nurse, appropriate school personnel, and/or my child's health care provider.

Guardian Signature_____ **Date**_____

Physician Authorization

(Required for ALL prescription medication authorizations)

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

☐ **Special Instructions,** including adverse reactions and action required

_____

_____ _____

Physician's Name *(please print/stamp)* ***Address/City/State***

_____ _____ _____

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