Est. 1883
BEND LAPINE
Schools
EDUCATING THRIVING CITIZENS

Authorization for Medication Administration Bv Bend – La Pine Schools Personnel

--Office Use
Student ID _____
Homeroom _____
Nurse Notification: ☐

1

Legal Last Name	Legal First Name	Legal Middle Name

Birth Date	Grade	Teacher's name (if known)
Month Day Year		

Please read the following statements and provide your initials as an approval or acknowledgment.

2. **All medication must be in its newest original container with accurate labeling.** _____ Initials
3. Parent / guardian is responsible for providing needed medication and maintaining the supply as needed. _____ Initials
4. Parent / guardian is responsible for picking up all unused medication by the last day of school. All medication left at the school will be discarded. _____ Initials
5. Parent / guardian accepts responsibility of notifying the school nurse or the school's main office staff in writing of any changes to the student's medication during the school year and after the date shown on this document. Changes to the prescription label or container directions must be in writing from the health care provider. _____ Initials
6. Medications:

Medication Name	Type	If the medication is prescription, please provide the RX number.
	☐ Non-prescription ☐ Prescription	
Start Date Month Day Year	End Date Month Day Year	Time of day

Dose	Frequency (how often)	Route
		☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin
Reason for Medication		Special Instructions:

7. Parent /Guardian Signature and Authorization

I verify that the above health information is accurate and complete, and I understand that it is my responsibility to notify the school office in writing promptly of changes to this information.

This authorization applies only to the medication listed above and the duration of treatment or school year.

This authorization provides permission to exchange information, as necessary, between the school nurse, school staff and / or my student's health provider.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: Telephone:

8. Physician Direction *Required in writing **OR** on pharmacy label for all prescription medications. Please read and initial the following:*

Instructions included with the medication (in the box or on the container) are accurate. _____ Initials

Special instructions including adverse reactions and action require:

_____

_____

Physician's Name (print /stamp): _____ Address: _____

Physician's Signature: _____ City, State, Zip Code: _____

Effective Date: _____ Telephone: _____