Lake Oswego School District

STUDENT ADMINISTERED

MEDICATION AUTHORIZATION

School District Nurse Phone (Student Services Office): 503-534-2359 Fax: 503-534-2288

Student Name:		
Date of Birth:		
School & Teacher:		
School Year & Grade:		

Medication Name:		**Dose:**	
Expiration Date:	Please check expiration date frequently. Expired medications should not be carried at school.		
Reason for Medication:		**Method of Administration** (by mouth, in the eye, on the skin, etc.):	
Possible Side Effects:			
Physician/clinic:			

Students who are developmentally and/or behaviorally able, will be allowed to self-administer prescription and nonprescription medication, subject to the following:

1. Permission form must be submitted for self-medication of all prescription and non-prescription medication. Physician or School District Nurse signature needed for prescription medications.
2. All prescription and nonprescription medication must be kept in its appropriately labeled, original container, as follows:
    a. Prescription labels must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions.
    b. Nonprescription medication must have the student's name affixed to the original container.
3. The **amount of medication** to be in the student's possession will depend on the type of medication and will be determined through the approval process.
4. Student will be solely responsible for maintaining possession of the prescription. LOSD staff will not be held liable if prescription is not available in case of emergency
5. Sharing and/or borrowing of medication with another student is strictly prohibited.
6. Permission to self-medicate may be revoked if the student violates school district policy governing administration of medication and/or these regulations. Additionally, students may be subject to discipline, up to and including expulsion, as appropriate.

I have read and agree to the above criteria. I give permission for my child to carry their medication. I give permission for the school district and the student's doctor to exchange information about this medication.

_____ _____

Parent/Guardian Signature **Date**

I agree to comply with the above criteria.

_____

_____

Student Signature **Date**

_____ _____

School Administrator Signature **Date**

_____ _____

Physician or District Nurse Signature (prescription meds ONLY): **Date**

▢ **Scan and Email to RN** ▢ **Put hard copy in binder**