Molalla River Academy

Authorization for Medication Administration

Student:	DOB:

I am giving school personnel *permission* to administer medications to my child per the following:

☐ **PRESCRIPTION: REQUIRES MEDICATION TO BE IN THE ORIGINAL CONTAINER WITH PRESCRIPTION LABEL; PRESCRIPTION MUST BE WRITTEN BY OREGON LICENSED PRESCRIBER. DOSAGE/DIRECTIONS MUST BE CONSISTENT WITH PRESCRIBER'S WRITTEN PRESCRIPTION.**

☐ **NON-PRESCRIPTION: REQUIRES MEDICATION TO BE IN THE ORIGINAL CONTAINER WITH DOSAGE AND DIRECTIONS VISIBLE. DOSAGE/DIRECTIONS MUST BE CONSISTENT WITH MANUFACTURER'S DOSAGE/DIRECTIONS OR WRITTEN ORDERS FROM A PRESCRIBER.**

Medication Name: **Dosage** (e.g. "5mg")

Route: ☐ Mouth (oral) ☐ Ear ☐ Eye ☐ Nose (Nasal) ☐ Skin (topical) ☐ Inhaled ☐ Injectable ☐ Other

Tablets that require cutting should be cut by the parents before being brought to school. Liquid medications require dosage spoons which are available from your pharmacist, and must also be supplied by parent.

Time of day to be given at school (**must be consistent with Rx label or manufacturer's directions**)**:** ☐ as needed ("PRN")

Duration: Start date: **End date:** ☐ last day of school

Reason for Medication:
Must be required for student to remain in school.

Special Instructions: ☐ Please allow my student to self –administer per signed agreement (back of form).

By signing this form I understand and agree that:

- As the parent I must provide and transport medication and maintain supply as needed.
- Notify the school in writing of any changes in medication or prescriber.
- Pick up all unused medication by the last day of school or it will be disposed of.

By signing below , I accept responsibility and authorize or acknowledge :

- Permission for the exchange of information between school personnel, school nurse and provider as necessary.
- That this agreement is only good for the individual, dose and medication listed on this form for the duration of one year or limitations of dates noted.

Parent Signature: ***Date:***

OREGON LICENSED PRESCRIBER'S DIRECTION

(Required in writing per OAR 581-021-0037 if the pharmacy label is not provided or if directions on this authorization deviate from the prescription label or manufacturer's directions of a non-prescription medication. This may include MD, NP, PA, ND, DO, OD, DDS. Prescriber should sign below.)

☐ I have prescribed the above medication for the student whose name appears on this form, and instructions are consistent with my medical directions which deviate from the prescription label or manufacturer's recommendations.

☐ Please allow this student to carry and self-administer this medication (as per agreement on the back of this form)

Oregon Prescriber's Name:	**Clinic/Contact Info:**
Oregon Licensed Prescriber's Signature:	

MRSD Board Policy JHCD, JHCDA, JHCD-AR; OAR 581-021-0037 **Initials:_____Date:_____**

Molalla River Academy

Self-Medication Agreement

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

1. This signed agreement must be submitted for any self-medication of <u>all</u> prescription and nonprescription medication (which requires :
   - ❑ Parent signature, if the student is under 18.
   - ❑ Permission from the prescriber; a prescription label prepared by a pharmacist will be deemed sufficient to meet the requirements for a prescribers order. If the directions deviate from the pharmacy label, the prescriber should sign the authorization (front of form) which authorizes that change.
   - ❑ The School RN must sign indicating a review of the order or rx label has occurred.
   - ❑ An Administrator must sign agreeing that this student does not pose behavioral or developmental risk with carrying medication in the school setting.
   - ❑ Student must sign the agreement indicating intent to comply with rules.

2. All prescription and nonprescription medication must be kept securely in the appropriately labeled, original container, as follows:
   - ❑ 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.
   - ❑ Nonprescription medication must have the student's name affixed to the *original* container with original label intact.

3. The student may have in his/her possession only the amount of medication needed for that school day.

4. Sharing and/or borrowing of medication with another student is strictly prohibited.

5. Permission to self-medicate may be revoked if the student violates state rules or school district policy governing administration medication and/or these regulations. I have read and agree to the above criteria and give permission for my child/self/student to self–carry and self-administer.

I have read and agree to the above criteria and give my child permission to carry the following medication:

☐ Albuterol MDI ☐ Epinephrine Auto-injector

Medication

Parent's Signature

Date

I agree to comply with the above criteria, and understand this privilege may change if contingencies are not met.

Student's Signature

Date

This student may carry and self-administer medication as prescribed: ☐ Pharmacy label ☐ Prescriber written order

School RN's Signature

Date

This student is developmentally and behaviorally capable of administering medication in the school setting.

School Administrator 's Signature

Date