Special Programs Office
520 N.W. Wall Street
Bend, Oregon 97703
(541) 355-1060

BEND-LA PINE SCHOOLS

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SELF

Student Name: _____ **School:** _____ **Grade:** _____

Student ID # _____

DOB: _____

Parent/Guardian Contact Information:

Name: _____ **Relationship to student:** _____ **Number:** _____

Name: _____ **Relationship to student:** _____ **Number:** _____

I am giving my student permission to self-administer medications:

☐ Prescription RX * ☐ Non-Prescription

Medication: _____

Dose: (how much) _____

Frequency: (how often) _____

Route: (check one)

By: ☐ **mouth** ☐ **ear** ☐ **eye** ☐ **nose**

☐ **Intramuscular** ☐ **subcutaneous** ☐ **skin**

Time: _____

Duration: Start date _____ End date _____

Reason for Medication:

Special Instructions:

To be completed by school nurse only

Nurse initials_____ Student understands reason for taking medication.

Nurse initials_____ Student understands medication administration dose.

Nurse initials_____ Student understands how often medication should be administered.

Nurse initials_____ Student understands how to take the medication.

For inhalers and injectable medications

Nurse initials_____ Student has demonstrated how to correctly administer the medication.

Students not meeting the above criteria will not be permitted to self-carry their medication and will need to have the medication administered by school staff.

Parent/Guardian Signature: _____ Date: _____

(*This authorization applies only to the medication listed above and for the duration of treatment or school year*). This also authorizes an exchange of information, as necessary, between the nurse, appropriate school personnel, and/or my student's health care provider.

****Students may only have in their possession the amount of medication needed for that day. ****

* PHYSICIAN DIRECTION

(Required in writing **or** on pharmacy label for all prescription medications)

I have prescribed the above medication for the student whose name appears at the top of this form.
Instructions in the box are accurate: ☐ Special Instructions including adverse reactions and action require:

_____

_____ _____

Physician's Name (Please print/stamp Address City State Zip

_____ _____ _____

Physician's Signature Phone # Effective Date

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SELF-MEDICATION AGREEMENT

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

1. An *Authorization for Medication Administration by Self* permission form must be submitted for all self-medication of all prescription and non prescription medication.

2. All prescription and non prescription 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. Non-prescription medication must have the student's name affixed to the original container.

3. With the exception of inhalers, the student may have in his/her possession only the amount of medication needed for that day.

4. Sharing and/or borrowing of medication with another student is against school district policy and will be treated as a drug infraction.

5. Permission to self-medicate may be revoked if the student violates school district policy governing administration of non-injectable medication and/or these regulations. Additionally, students may be subject to discipline, up to and including expulsion, as deemed appropriate.

Student Name: _____ School: _____

I have read and agreed to the above criteria and give permission for my student to carry his/her medication.

_____ _____
Parent/Guardian Signature Date

I agreed to comply with the above criteria.

_____ _____
Student Signature Date

Revised 4-2-20