Coburg Charter School
Authorization for Medication Administration
by School Personnel
Board Policy JHCS/JHCDA

Student Name______________________________________ Birthdate__________________________
Grade___________________________

I am giving school personnel permission to administer medications to my child per the following:
Parent to complete separate form for each medication and for each dosage or time change:

Medication: ___________________________ ___ Non Prescription
Medicina *Sin Recta*
Dose (how much):______________________ ___ Prescription Rx number___________ Exp. Date:______
Dosis *Receta*
Frequency (how often): ___________ ___ Please allow my child to self-administer this medication
Frequencia (refer to medication policy)

Route: (circle one) **By: Mouth Ear Eye Nose Skin**
Boca oido ojo nariz piel

Time: ______________________ Duration: Start date____________ end date___________
Hora *Fechas para empezar y terminar*

Reason for Medication: ____
La razon para la medicina
Special Instructions: ____

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*I understand I am responsible to provide this medication in the **<u>most current pharmacy container with accurate label</u>** or **<u>manufactured packaging</u>** and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Any discrepancy between pharmacy label directions must be accompanied by signed orders from an Oregon Licensed Prescriber per OAR 581-021-0037. Parents are required to* **<u>pick up all unused medication</u>** *by the last day of school.*
All medication left at the school on the last day will be discarded.

<u>Parent/Guardian Signature</u>: ____ Date:__________
Phone:_________________
(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 school nurse, appropriate school personnel, and/or my child's health provider.
Health care provider's name is: ____

Health care provider's phone is: ________________________

<u>ADMINISTRATOR APPROVAL*(when necessary for self-administration of medication)</u>

Administrator Signature:_________________________ _______________ Date:________________

Coburg Community CHARTER SCHOOL 1865

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Drop off / Pick Up Medication Log **School Year 20_____ - ______**

Date	Time	Notes	Parent Initials	Staff Initials