Three Rivers Charter School

503-673-7850

Authorization for School Personnel to Administer Medications

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

1. Medication Name:	
2. Medication Dose:	
3. Method of Administration (by mouth, in the eye, on the skin, etc.)**:**	
4. Time(s) to be given at school	
5. Duration (specific range of dates, or all school year)**:**	
6. Reason for Medication:	
7. Possible Side Effects:	
8. Physician/clinic:	

Parent/Guardian Request/Approval

I hereby request and give my permission for the above named student to receive the specified medication as stated in the above instruction. I understand that the school administration will designate specific staff to administer medication, train staff, assure proper identification and safekeeping of medication, and maintain records of such administration of medication.

I understand I am responsible to provide this medication and maintain the supply as needed, and that I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

I further understand that school personnel who provide assistance (administration of specified medication so noted) or employer of such staff are not liable in any way civil or criminal, for any adverse reaction suffered by my child as a result of taking the medication so indicated and discontinuing the administration of the medication in keeping with the procedure outlined above. This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

Parent/Guardian Signature:	**Date:**