OAK RIDGE SCHOOLS
AUTHORIZATION FOR MEDICATION ADMINISTRATION DURING SCHOOL HOURS

The medication administration policy of the Oak Ridge School System states: every effort should be made to avoid the necessity of children being given medication at school. If under exceptional circumstances a student is required to take medication during school hours, only the school nurse or the principal's designee may assist the student. It is the parent/guardian's responsibility to bring this medication to school and remove any unused medication when treatment is completed. (Prescription medication must have a proper pharmacy label. Non-prescription medication must be in a new **UNOPENED** container with current expiration date.) All medication shall be kept in a locked container. (Inhalers may be kept with student if noted by physician below. Parent and student must sign the Medication Exemption form ORS-191ES). **Written authorization is for the current school year only.**

Medication to be given on a short-term basis (two weeks or less), prescription or non-prescription with adequate instructions provided, requires the **PARENT** to complete and sign.

Medication to be given longer than two weeks, the **PARENT** and **PHYSICIAN** portions of the form must be completed.

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

STUDENT NAME:_____SCHOOL:_____BIRTHDATE:_____SEX:_____

NAME OF MEDICATION:_____REASON FOR MEDICATION:_____

Allergies: ☐ None or Describe: _____ Type of Reaction:_____

Form of medication/treatment:_____

Dosage:_____ Schedule (Time(s) of administration):_____

Restrictions and/or important side effects: _____ None anticipated _____Yes **PLEASE DESCRIBE:**

_____Special Storage

Requirements: _____None _____Refrigerate _____Other (Describe)

The student is both capable and responsible for assisted self-administering this medication:
_____Yes, with supervised assistance _____No, student **cannot** administer
_____Student may carry this medication (**Emergency meds only – Inhaler, Epi Pen, Benadryl, Glucagon)**

Physician's Signature_____ Date_____
Physician's Name:_____ Address:_____ Phone Number:_____

TO BE COMPLETED BY PARENT/GUARDIAN

It is understood that the medication is administered to the student listed above solely at the request of and as an accommodation by the undersigned parent or guardian. I give permission for my child to be assisted with the medicine(s) described above at school by authorized persons or permitted to medicate herself/himself as also authorized by me and the physician.

***I give permission to the Oak Ridge Schools to contact the prescriber for questions. _____YES _____N0**

I agree to release the Oak Ridge School System and its personnel from any liability arising out of the administration of the medication to the student. **I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication.**
Parent Signature:_____ Phone Number:_____ Date:_____

THE FOLLOWING TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____ Medication shall be kept by: _____ Office _____ Teacher _____ Student _____ Clinic

Signature of school personnel to administer medication:_____ Date: _____

ORS-191

THIS FORM IS NON-TRANSFERRABLE