

## HILLSBORO SCHOOL DISTRICT MEDICATION AUTHORIZATION FORM

Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_ ID #: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**PLEASE FILL OUT FOR ALL MEDICATIONS**

Name of medication _____	Prescription number (unless OTC*) _____
Mg per tablet or teaspoon _____	Dosage to be given _____
Physician's name _____	Physician's phone number _____
Hours between doses _____	Amount in container _____
Given at home in the morning? _____	When _____
Time(s) to be given at school _____	Discontinue date _____
Reason for medication to be given at school _____	
Special Instructions _____	Expiration Date _____
Student carrying medication? _____	
<b>(Must have a parent's signature on Self-Administration form and a doctor's order to carry prescription medications.)</b>	
*Over-the-counter medication	

I hereby request and authorize school staff to give this medication in accordance with the instructions provided on the prescription label or OTC label. Staff cannot deviate from the directions provided on the label without a letter from the doctor. I understand that school staff will not be held liable for administering this medication. I authorize the school to release this information to appropriate staff members. **I also authorize the release and exchange of information with the physician regarding this medication.**

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

➤ **I have read and received the Medication Authorization Form Information For Parents \_\_\_\_\_ (parent initials)**

**REFILL INFORMATION**

Date: _____	Prescription Number: _____	Exp. Date: _____	Count: _____	Staff Initials: _____	Parent Signature: _____
Date: _____	Prescription Number: _____	Exp. Date: _____	Count: _____	Staff Initials: _____	Parent Signature: _____
Date: _____	Prescription Number: _____	Exp. Date: _____	Count: _____	Staff Initials: _____	Parent Signature: _____
Date: _____	Prescription Number: _____	Exp. Date: _____	Count: _____	Staff Initials: _____	Parent Signature: _____

**CHANGE IN DIRECTIONS REGARDING THIS MEDICATION: (Start new Medication Record\*\*)**

Date: \_\_\_\_\_ Direction Change: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Direction Change: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

**DISCONTINUE MEDICATION:**

Date: \_\_\_\_\_ Pill count returned to parent: \_\_\_\_\_ Staff Initials: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Staff signature(s): \_\_\_\_\_  
\_\_\_\_\_

Medication Review/RN Signature: \_\_\_\_\_

**Administering Noninjectable Medicines to Students  
and Self-Medication by Students**

The District recognizes that administering of medication to students and self-medication may be necessary when the failure to take such medication would jeopardize the health of the student or the student would not be able to attend school if medication were not made available during school hours. Consequently, students may be permitted to take noninjectable prescription or nonprescription medication at school on a short-term or recurring basis.

When directed by a physician or other licensed health care professional, students in Grades K-12 will be allowed to self administer medication. A medical protocol regarding each student who self administers medication will be developed, signed by a physician or other licensed health care professional, and parent, and kept on file. Permission for self-administered medication may be revoked at any time if the student violates policy or medical protocol.

All requests for the district to administer medication to a student shall be made by the parent in writing. Requests shall include the written instructions of the physician for the administration of a prescription medication to a student or the written instructions of the parent for the administration of a nonprescription medication to a student. A prescription label will be deemed sufficient to meet the requirements for written physician instructions.

The District shall designate school staff authorized to administer medication to students. Training shall be provided as required by law.

The District reserves the right to reject a request to administer prescription or nonprescription medication when such medication is not necessary for the student to remain in school.

This policy and administrative regulation shall not prohibit, in any way, the administration of first aid to students by district employees in accordance with established state law, Board policy, and procedures.

The Superintendent shall develop administrative regulations as needed to meet the requirements of law, Oregon Administrative Rules, and for the implementation of this policy. Regulations will include provisions for student self-medication.

**END OF POLICY**

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Legal Reference(s):

ORS 109.640  
ORS 339.867  
ORS 339.869

ORS 399.870  
ORS 433.805 - 433.830  
ORS 475.005 - 475.285

OAR 581-021-0037  
OAR 581-022-0705  
OAR 166-400-0010(17)  
OAR 166-400-0060(29)