

**Central Linn School District**  
**Authorization for Medication Administration by School Personnel**

To: \_\_\_\_\_ of: \_\_\_\_\_  
(Administrator's Name) (School Name)

Student Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

I am giving school personnel permission to administer medications to my child per the following:

Parent or Physician to complete:	
Medication: _____	
<input type="checkbox"/> Non Prescription <input type="checkbox"/> Prescription Rx # _____	
Dose (how much): _____	
Frequency (how often): _____	
Route (circle one):    Mouth    Ear    Eye    Nose    Skin	
Time medication is to be administered: _____	
Duration: Start date: _____	End Date: _____
Reason For Medication:	
_____	
_____	
Special Instructions:	
_____	
_____	

- \_\_\_ Please allow my child to self-administer this medication (refer to district policy on self medication).
- \_\_\_ Please send this medication on field trips that overlap dosage times.

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

\_\_\_\_\_  
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 school nurse, appropriate school personnel, and/or my child's health provider.*