The Early Learning Community at Pacific University
503.352.1481 | pacificu.edu/elc | Berglund Hall | Corner of Pacific Avenue and Cedar Street

Administering Medications

This form must be completed and returned to school if a child requires a prescription medication to be given during school hours or must have a non-prescription medication during the school day.

OREGON LAW REQUIREMENTS:
Prescription medications must be in the original pharmacy container with an accurate prescription label. Written instructions from a state licensed care provider (prescription label meets this requirement) and signed permission and instruction from the parent are necessary**. Non-prescription medications** must be commercially prepared, in the original container and non-alcohol based. The parent must provide written permission and instruction. **Please do not allow children to bring medications to school to take themselves.** This is not safe for other children who may find and take these medicines. Arrangements can be made for the asthmatic student who requires immediate access to an inhaler.

PARENTAL PERMISSION AND INSTRUCTION:

1. Child's Name: _____ Birthdate: _____ Class: _____
2. Name of Medication: _____
3. Dates to be administered: _____
4. Time to be given each day: _____
5. Dosage (amount) to be given: _____
6. Medical condition for which this treatment is given: _____

_____

The ELC at Pacific University has my permission to administer the above medication to my child according to the pharmacy label directions and/or the instruction provided above.

_____	_____	_____
Signature of Parent or Guardian	*Name printed*	*Date*

VERIFICATION OF MEDICATION ADMINISTRATION:

Date	Time	Person Administering	Date	Time	Person Administering

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Administering Medications – Page 2 – to be used only as attachment to completed first page

This form must be completed and returned to school if a child requires a prescription medication to be given during school hours or must have a non-prescription medication during the school day.

SEE PAGE ONE (ATTACHED) FOR FULL PARENTAL PERMISSION AND INSTRUCTION:

1. Child's Name: _____ Birthdate: _____ Class: _____
2. Name of Medication: _____
3. Dates to be administered: _____
4. Time to be given each day: _____
5. Dosage (amount) to be given: _____
6. Medical condition for which this treatment is given: _____

VERIFICATION OF MEDICATION ADMINISTRATION:

Date	Time	Person Administering	Date	Time	Person Administering