AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Edmond Public Schools **Fax #** _____

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student_____ **Birthdate**_____ **Grade**_____ **School Year** _____

School_____ **Teacher**_____ **Date received** _____

- **TO BE COMPLETED BY THE LICENSED PHYSICIAN OR PRESCRIBER**

1. **Reason for medication** _____
2. **Name of medication** _____
3. **Dosage** _____
4. **Time to be administered** _____
5. **Duration (week, month, indefinite, etc.)** _____
6. **Side Effects: ☐ None Expected ☐ Specify** _____

   _____
7. **Form of medication/treatment: Tablet____ Liquid____ Inhaler____ Injection____ Nebulizer____ Other_____**
8. **Special storage requirements: None _____ Refrigerate _____**

_____ _____ _____

Licensed Prescriber Signature **Name (please print)** **Date**

_____ _____ _____

Address **Phone** **Fax**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. "Over the counter medication" must be in the original, unopened container. All medication must be brought to school by an adult. I further understand that I will be responsible for picking up any remaining medication at the end of the school year; medication will NOT be sent home with students. Any medication remaining after the school year has ended will be discarded utilizing proper procedure. The school nurse may consult with the prescriber regarding this prescription. Changes to the time and/or dosage of the medication require written authorization from the licensed prescriber and parent/guardian.

_____ _____

Parent/Guardian Signature **Date**

COMPLETE THE SECTION BELOW ONLY IF PRESCRIBING ASTHMA, ANAPHYLAXIS OR DIABETES MEDICATION TO BE CARRIED BY THE STUDENT

SELF-ADMINISTRATION OF ASTHMA, ANAPHYLAXIS, AND DIABETES MEDICATION ONLY

TO BE COMPLETED BY THE LICENSED PHYSICIAN/PRESCRIBER:

- **This student has been instructed and is capable and responsible to self-administer this medication: Yes ____ No ____**
- **This student may carry this medication on their person: Yes____ No____**

_____ _____

Licensed Prescriber Signature (Required) **Date**

- **TO BE COMPLETED BY THE PARENT/GUARDIAN:**

Authorization for Self-Administration of Medication

THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY MY STUDENT/CHILD. PURSUANT TO OKLAHOMA LAW, I UNDERSTAND I AM *REQUIRED TO PROVIDE THE SCHOOL WITH AN EMERGENCY SUPPLY OF THE MEDICATION(S).*

_____ _____

Parent/Guardian Signature **Date**

I will not knowingly share my medication with another student.

_____ _____

Student Signature **Date**