EDMOND PUBLIC SCHOOLS **RETURN TO** _____
Authorization for the Administration of Medication **FAX** _____

Authorization and Request for the Administration of Medication at school to be used when a physician orders:

A. Prescription Medication
B. Medication that is to be given only when needed
C. Non-prescription or "over-the-counter" medication

Student _____**Birthdate** _____
School _____ **Teacher/Classroom** _____**Grade** _____
Date form received by the school:_____

- **TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER**
  1. **Reason for medication** _____
  2. **Name of medication** _____
  3. **Dosage/amount to be given** _____
  4. **Specific time to be administered** _____
  5. **Duration (week, month, indefinite, etc.)**_____
  6. **Anticipated reaction to medication (symptoms, side effects, etc.)**_____
     _____
  7. **Form of medication/treatment** _____
     Tablet____ Liquid____ Inhaler____ Injection____ Nebulizer____ Other_____
  8. **Special storage requirements**
     None_____ Refrigerate_____

_____ _____ _____
Physician's Signature **Physician's Name (please print)** **Date**

_____ _____ _____
Address **Phone** **Fax**

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- **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 to my child. If the medication is prescribed by a physician, the pharmacy label must be attached to the medication. If this medication is an "over the counter medication" it must be brought in the original container/box. I further understand that I will be responsible for picking up any medication at the end of the school year. Any medication left at school after June 1st will be discarded utilizing proper procedure.

_____ _____
Parent/Guardian Signature **Date**