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:**_____

Phone:_____ Teacher/Classroom:_____Grade:_____

School:_____Phone:_____Fax:_____

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**