EDMOND PUBLIC SCHOOLS **RETURN TO: _____**

Authorization for the Administration of Medication **FAX # _____**

One Medication per Form

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:_____ Grade _____

School:_____ Date school received form _____

- **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**

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

★ **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 PHYSICIAN OR AUTHORIZED PRESCRIBER:

- **This student is both capable and responsible for self-administering this medication: No _____ Yes _____**
- **This student may carry this medication on his/her person: No_____ Yes_____**

_____ _____

Physician's Signature (Required) **Date**

- **TO BE COMPLETED BY THE PARENT/GUARDIAN:**
  THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM YOUR CHILD SELF-ADMINISTRATING MEDICATION AT SCHOOL. IF YOU'RE CHILD HAS PARENTAL PERMISSION TO CARRY THEIR ASTHMA, ANAPHYLAXIS, OR DIABETES MEDICATION(S) WITH THEM *YOU ARE REQUIRED TO PROVIDE THE SCHOOL WITH AN EMERGENCY SUPPLY OF THE MEDICATION(S) TO BE ADMINISTERED PURSUANT TO OKLAHOMA LAW.* PARENT/GUARDIAN SIGNATURE BELOW IS GRANTING YOUR CHILD PERMISSION TO SELF-ADMINISTER HIS/HER MEDICATION AT SCHOOL.

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 remaining at school at the end of the school year. Any medication left at school after June 1st will be discarded utilizing the proper procedure.

_____ _____

Parent/Guardian Signature Date

I will not knowingly allow another student to take my medication.

_____ _____

Student Signature Date