

**Oklahoma City Public Schools
Health Services
Permission Form for Prescribed Medication**

School: _____ Phone # _____ Fax # _____

Date form received by the school: _____

Student: _____ Date of birth or age: _____

Grade: _____ Teacher/Classroom: _____

• **To be completed by the physician or authorized prescriber:**

Reason for medication: _____

Name of medication: _____

Form of medication/treatment: _____

Tablet Liquid Inhaler Injection Nebulizer Other

• **Instructions (Schedule and dose to be given at school):** _____

Start: Date form received Other date: _____

Stop: End of school year Other date: _____

For episodic/emergency events only

Restrictions and/or important side effects: None anticipated Yes

Please describe: _____

Special storage requirements: None Refrigerate

Physician's Name: _____ Signature: _____

Phone: _____ Fax #: _____

• This student is both capable and responsible for self – administering this medication:

No Yes-Supervised Yes-Unsupervised

This student may carry this medication on his/her person: No Yes

Physician's Name: _____ Signature: _____

Address: _____ Phone number: _____

Fax # _____

• **To be completed by the parent/guardian:**

The district shall incur no liability as a result of any injury arising from your child self-administering medication at school.

Date: _____ Signature of Parent: _____

• **To the school:**

Please report concerns about medications or disease to the above physician.

• **To be completed by the principal:**

Date: _____ Name of school employee(s) designated by the principal or nurse to administer the medication _____

• **To be completed by parent/guardian:**

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy.

Medication must be brought to school in the original container

Date: _____ Signature: _____ Relationship: _____

Phone: _____ Location: _____