Oklahoma City
PUBLIC SCHOOLS

Authorization for the Administration of Medication

Student Name: _____ DOB: _____ School Year: _____
School: _____ Phone: _____
Teacher: _____ Grade: _____

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

1. Name of Medication:_____
2. Reason for Medication: _____
3. Dosage: _____ Time to be administered: _____
4. Duration of medication (week, month, indefinite, etc): _____
5. Side Effects(circle one)? Yes / No If yes, specify: _____
   _____
6. Form of medication/treatment: ☐ Tablet ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____
7. Special Storage Requirements: ☐ None ☐ Refrigerate

LICENSED PRESCRIBER SIGNATURE | PRINTED NAME | DATE

ADDRESS | PHONE | FAX

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

I have read the Authorization for Administration of Medication on the reverse side of this form and I hereby request and authorize Oklahoma City Public Schools personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless Oklahoma City Public School and any of their officers, staff members, or agents from lawsuit, claim, demand or action against them for administering the above mentioned medication(s) to my child. I understand that permission is granted for exchange of verbal and/or written communication between RN/LPN staff and the prescribing provider regarding this medication.

This document serves for my child to have medications(s) administered from an approved trained school personnel while on a school-sponsored field trip/activity during school hours.
I also understand that any remaining medication must be picked up by a legal parent/guardian on or before the last day of school or the medication will be destroyed.

This form expires at the end of the current academic school year (including summer school).

PARENT/GUARDIAN SIGNATURE | DATE

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

(Complete ONLY if prescribing these medications to be carried by the student)

****TO BE COMPLETED BY 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 (REQUIRED) | PHONE | DATE

If it is necessary, that a medication be given during school hours the following requirements must be met: By signing the Medication Request and Release, the parent/guardian with legal custody understands that under state law; OKCPS Board of Education, Oklahoma City Public School District, or employees of the District shall not be liable to the student or student's parent or guardian for civil damages for any personal injuries to the student which result from acts of omissions and/or adverse effect of this medication. Over-the-counter medications must be in an unopened original container. Student's name must be written on the box/bottle, the dosage and frequency to be given must be consistent with label instructions. Medication cannot and will not be accepted in bags or envelopes. Medication will not be administered in school or during school-sponsored activities without a current year Medication Request and Release filled out properly and signed by a legal parent or guardian and on file. Prescription medication must be ordered or advised by a licensed physician/dentist, and permission is granted for exchange of verbal and/or written communication between the school staff and the prescribing provider regarding this medication. Prescription medication must be brought to school in the current original container with the pharmacy label intact. The label must have the student's name, name of medication, dosage, and time to be given. The prescribing provider MUST sign and date the completed Medication Request and Release. If the medication is not properly labeled or does not match the Medication Request and Release, it will not be given. Parents/guardians may ask the pharmacist for a separate container labeled just for the school time dose. For student's safety; it is recommended that the parent/guardian bring the medication to the school and give directly to Health Services staff. The school cannot send medications home with students. At the end of the school year, any medication remaining must be picked up by the legal parent/guardian, on or before the last day of school or, the medication will be destroyed. The parent/guardian agrees to provide medication and any particulars connected with administering medication at their own expense. The parent/guardian will promptly notify the school of any change in the administration of this medication and will provide the school with new prescription bottle and new Medication Request.