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 hereby request and give my permission for the above named school to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. "Over the counter medication" must be in the original, unopened container. All medication must be brought to school by an adult. I further understand that I will be responsible for picking up any remaining medication at the end of the school year; **medication will NOT be sent home with students**. Any medication remaining after the school year has ended will be discarded utilizing proper procedure. The school nurse may consult with the prescriber regarding this prescription. Changes to the time and/or dosage of the medication require written authorization from the licensed prescriber and parent/guardian.

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