MEDICATION AUTHORIZATION FORM

Student's Name:_____ DOB:_____

Grade: _____ Allergies: _____

☐ I request that authorized persons at my child's school assist my child in taking the prescription or over-the-counter medication(s) described below at the time indicated by this authorization form. Please list each medication that you would want your child to be able to take while at school. **MEDICATIONS MUST BE LISTED IN THE TABLE BELOW. ALL PRESCRIPTION MEDICATIONS MUST HAVE A LISCENSED PRESCRIBER'S SIGNATURE ON THIS FORM BEFORE MEDICATION CAN BE ADMINISTERED.**

☐ I request that my child allowed to self-carry and self-administer medication. I shall hold harmless and indemnify the Oaks-Mission School District, its agents, employees, and board members against all claims, judgements, or liability arising out of self-administration and carrying of medication by my child. **ONLY SELCT THIS OPTION IF YOUR CHILD IS ABLE TO SELF-CARRY AND SELF-ADMINISTER AN EPIPEN AND/OR INHALER. OTHERWISE, ALL MEDICATIONS MUST BE STORED IN THE HEALTH OFFICE.**

- I or a responsible adult, will be responsible for bringing the prescription or over-the-counter medications to school in a labeled container from the pharmacist or the manufacturer's container.
- I also understand that I am responsible for maintaining enough medication at the school. Failure to do this will result in an interruption of the licensed prescriber's order or discontinuation of the school's administration of the medication for my child.
- I understand that, if my child refuses to take the medication(s) the medication(s) will not be given, and the parent will be notified.
- I understand that medication(s) must be dropped off and picked up by a responsible adult and cannot be sent to school or back home with the student.
- I authorize that the school nurse may contact the prescriber of these medication(s), as allowed by HIPAA, if a question may arise about my child or my child's medication(s).

_____ _____ _____

Signature of Parent/Legal Guardian | Relationship to Student | Date

_____ _____

Printed Name Of Parent/Legal Guardian | Phone Number

MEDICATION NAME	REASON FOR MEDICATION	DOSE	ROUTE	FREQUENCY

_____ _____

Licensed Prescriber's Signature | Date

_____ _____

Printed Name of Licensed Prescriber | Phone Number