



Oklahoma City Public Schools  
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_  
School \_\_\_\_\_ Teacher \_\_\_\_\_ Date received \_\_\_\_\_

• TO BE COMPLETED BY THE LICENSED PHYSICIAN OR PRESCRIBER

1. Reason for medication \_\_\_\_\_
2. Name of medication \_\_\_\_\_
3. Dosage \_\_\_\_\_
4. Time to be administered \_\_\_\_\_
5. Duration (week, month, indefinite, etc.) \_\_\_\_\_
6. Side Effects:  None Expected  Specify \_\_\_\_\_
7. Form of medication/treatment: Tablet \_\_\_\_\_ Liquid \_\_\_\_\_ Inhaler \_\_\_\_\_ Injection \_\_\_\_\_ Nebulizer \_\_\_\_\_ Other \_\_\_\_\_
8. Special storage requirements: None \_\_\_\_\_ Refrigerate \_\_\_\_\_

**Licensed Prescriber Signature**

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. 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. **Substances not approved by the FDA will not be stored nor administered by school personnel.** 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.

I understand and acknowledge the above statement.  I do not understand and acknowledge the above statement.

**Parent/Guardian Signature**

Date

**COMPLETE FOR SELF-ADMINISTRATION AND/OR SELF CARRY OF  
ASTHMA, ANAPHYLAXIS, REPLACEMENT PANCREATIC ENZYME AND DIABETES MEDICATION ONLY**

TO BE COMPLETED BY THE 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 and/or Self-Carry of Medication

**THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION AND/OR SELF-CARRY 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).**

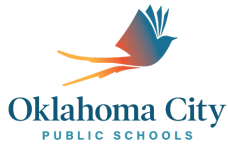
**Parent/Guardian Signature**

Date

I will not knowingly share my medication with another student.

**Student Signature**

Date



# 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
--------------------------------------	-------	------