Oak Ridge
SCHOOLS

Authorization for Medication Administration Form

This Form is Valid for One School Year Only

The following is to be completed by a parent and health care provider, if applicable. No medication of any kind will be given to your child until this information is completed and returned to the school.

- Medication must be brought to the school by a responsible adult. **Do not send medication with student.**
- All prescription medication must be in a **pharmacy-labeled container**. This prescription bottle will have the date, student's name, type, dosage, and frequency of medication.
- Over-the-counter medication must be provided in an unopened, unexpired, original container with the student's name and date of birth.
- If any changes in medication/dosage occur during the school year, a new form must be completed along with a new pharmacy-labeled container and returned to the school.
- **Only one form for each medication is to be used.**
- A **parent signature** is required before a student can be assisted with self-administration of medication.
- Any unused medication will be destroyed at the end of the current school year if not retrieved by the parent/guardian.

Student Name: _____ Date of Birth: _____ Grade: _____

Allergies: _____

MEDICATION INFORMATION: ☐Prescription Medication ☐ Non-Prescription/ Over-the-Counter

Diagnosis Requiring Medication: _____

Medication Name: _____ Dosage and Route: _____

Administration Time/Frequency: _____ Start Date: _____ End Date: _____

Special Storage Requirements: ☐ None ☐Refrigerate ☐Other- If other, describe: _____

Potential Side Effects and Procedure to Manage: _____

PHYSICIAN'S AUTHORIZATION: Required for all prescription medications.

The above-named student is under my medical care and requires this medication to be given at school. The student is both capable and responsible for assisted self-administering this medication.

☐ Student may self-carry this medication (Emergency Meds Only- Inhaler, Epi Pen, Glucagon, Pancreatic Enzymes)

Physician's Signature: _____ Date: _____

Physician's Name (Print): _____ Phone: _____

PARENT/GUARDIAN'S AUTHORIZATION: Required for all medications.

I acknowledge the above-named student is competent to self-administer this medication with assistance from the school nurse or designated trained personnel. I consent to communication between the school nurse and prescribing health care provider/clinic to discuss administration and use of this medication. I agree that the Oak Ridge Board of Education shall incur no liability and be held harmless against any claims of injury related to the administration of such medication. I will assume full responsibility for any side effects/complications that my student may have as a result of taking this medication.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Name (Print): _____ Phone: _____

School Staff Only:

Completed form received on _____ by _____ Exp Date of Med: _____
Date Signature