GPS

Staking A Claim in Our Students' Future

Phone 405-282-8900

MEDICATION AUTHORIZATION FORM

Student_____ Date of Birth_____ School Year_____ Grade_____

Parent/Guardian_____ Phone_____

Health Provider's Name_____ Phone_____ Fax_____

TO BE COMPLETED BY PHYSICIAN/LICENSED PRACTITIONER:

- Reason for medication_____
- Name of medication_____
- Dosage_____
- Time and Route for be administered_____
- Duration (week, month, indefinite, etc.)_____
- Possible side effects (if expected)_____

_____ _____

Physician/Licensed Practitioner's Signature **Date**

TO BE COMPLETED BY PARENT/GUARDIAN:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child. Prescription medication must have the pharmacy label attached and must match the written prescriber's order. Over the counter medication must be in the original, unopened container. All medication must be brought by an adult and will be kept securely with trained school personnel for the duration of the school year unless the student is approved by prescriber to self carry. 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 medication. Changes to the time and/or dosage of the medication require written authorization from the prescriber.

I understand that under the state law the Board of Education, the School District, or employees of the School District shall not be liable to the student or the student's parents or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine or assisting in the application of sunscreen I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

_____ _____

Parent/Guardian Signature **Date**

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SELF CARRY/ADMINISTRATION AUTHORIZATION CONTINUED ON PG 2

COMPLETE ONLY FOR SELF ADMINISTRATION OF ASTHMA, ANAPHYLAXIS, REPLACEMENT PANCREATIC ENZYMES, OR DIABETIC MEDICATIONS

TO BE COMPLETED BY THE PHYSICIAN/LICENSED PRACTITIONER:

- 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_____

_____ _____

Physician/Licensed Practitioner's Signature **Date**

TO BE COMPLETED BY PARENT/GUARDIAN:

I hereby give permission to my child to self-administer and/or self carry his/her medication at school. THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF ADMINISTRATION OF MEDICATION BY MY 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**

TO BE COMPLETED BY PARENT/GUARDIAN FOR APPLICATION OF SUNSCREEN:

I desire that the school assist the student in applying sunscreen. I understand that the student may possess and self-apply sunscreen without my written permission. I hereby give my consent and authorize the school nurse, the principal, or the employee of the school district designated by the principal and school nurse to assist the student in applying sunscreen:

_____ sunscreen, which I am hereby supplying you, in accordance with the label directions.

_____ sunscreen, which I am hereby supplying you, in accordance with written directions of the student's physician which I have attached.

_____ _____

Parent/Legal Guardian Signature **Date**