# Medication Request and Release Form

Student: _____ Grade _____ Teacher: _____

**OVER-THE-COUNTER MEDICATION** **TO BE COMPLETED BY THE PARENT**

Fill out and return to school with a **New Unopened Container** of age and dose appropriate medication

Medication: _____ Dosage: _____

Purpose: _____ Time(s) to be administered: _____

**PRESCRIPTION MEDICATION** **TO BE COMPLETED BY THE PHYSICIAN**

Public Schools discourage the administration of medication to students in school if possible. This form will only be valid for the current school year. A new form is required yearly.

**PLEASE USE A SEPARATE FORM FOR EACH MEDICATION**

Medication: _____ Diagnosis: _____
Trade Name and/or Generic

Dosage: _____ Time(s) to be given at School: _____

Method of administration: ORAL Liquid Tablet Inhaler DROPS Eye R L Ear R L
TOPICAL apply where_____ OTHER _____

Effective Dates: From____/____/____ to ____/____/____

Possible Side Effects: _____

If medication is PRN (as needed), please specify: _____
Signs and Symptoms

_____ Can Medication be Repeated? Yes No How Many Times? _____
Frequency of Administration

_____ _____ _____ _____
Physician's Name (Please Print) Physician or Representatives Signature Physician's Phone Date

**** SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**

Provisions under 70 O.S. 1984, Section 1-1163, allow students to self administer prescribed asthmatic, diabetic, or allergic medication. Approval to self administer medications must be authorized by the prescribing physician. **The parent or guardian of the student is to *provide the school an emergency supply* of the student's medication.**

☐ I have instructed _____ in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.

_____ ____/____/____
Physician's Signature Date

***granted* for exchange of verbal and/or written communication between the school staff and the prescribing physician/dentist regarding this medication**

_____ ____/____/____ _____
**Signature of Legal Parent/Guardian** Date Contact Phone