OAK MEADOW SCHOOL

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PERMISSION TO ADMINISTER PRESCRIBED MEDICATION

All information must be filled in by parent/guardian and signed by a physician to enable Oak Meadow School staff to administer prescribed medication*.

Child's Name: _____ DOB: _____

Name of Medication: _____ Date Prescribed: _____

Allergies: _____

Reason for Medication (problem or illness): _____

I, _____ give permission to the School Nurse and/or
(parent/guardian)
other school personnel, designated by the School Nurse, to administer _____
(amount)
of _____ to my child, named above,
(name of medication)

on _____ at approximately _____
(dates and days) (time dose is due)

Possible side effects to watch for with this medication: _____

I give permission for my son/daughter to self-administer medication, if the School Nurse determines it is safe and appropriate. _____ Yes _____ No

Name of Prescribing Physician: _____

Physician's Phone Number: _____

Physician's Signature: _____ **Date**: _____

Parent/Guardian Signature: _____ **Date**: _____

* Medications should be delivered to the School Nurse in a pharmacy or manufacturer-labeled container. Please ask your pharmacy to provide separate bottles for school and home. Please pick up all medications by the end of the school year. Any medications left after one week of school closure in June will be disposed of.