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.