MEDICAL AUTHORIZATION FORM

OAK GROVE SCHOOL
The Art of Living and Learning

This form must be completed by the parent/guardian and/or by a physician before any medication may be administered by school personnel. Please complete one form for each medication used. The parent/guardian must bring all medication to school in the original container (pharmacy container for prescription medication).

If your physician would like your student to carry emergency medication (e.g. asthma inhaler or EpiPen), Part IV must be completed by the doctor, parent, and student. It is the parent/guardian's obligation to immediately provide Oak Grove School with a new Medication Authorization if there is any change to the dose, time, method of administration, medication, doctor, or a discontinuation of medication.

Name of Student _____ **Date of Birth** _____

I. MEDICATION AUTHORIZATION — Parent/guardian authorization for over-the-counter medication

Name of medication _____
Form of medication:
Tablet/capsule ☐ Liquid ☐ Cream ☐ Other _____
Dosage (specify exact milligrams if a tablet) _____

Allowable frequency for administration _____
Symptoms necessitating administration _____
Special storage instructions _____
Restrictions and/or important side effects _____

Indications warranting referral for medical evaluation _____
Printed name of physician _____
Phone _____

II. PHYSICIAN'S AUTHORIZATION — For prescription medication

A. MEDICATION TAKEN ON A REGULAR BASIS

Name of medication _____ Start date _____ Stop date _____

Form of medication:
Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐
Other _____
Dosage (specify exact milligrams if a tablet) _____

Time of administration at school _____
Special storage instructions _____
Restrictions and/or side effects _____

B. MEDICATION TAKEN ON AN AS-NEEDED BASIS

Name of medication _____ Start date _____ Stop date _____

Form of medication:
Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐
Other _____
Dosage (specify exact milligrams if a tablet) _____
Time of administration at school _____

Special storage instructions _____
Restrictions and/or side effects _____
Allowable frequency for administration _____
Symptoms necessitating administration _____

Indications warranting referral for medical evaluation _____
Printed name of physician _____
Physician phone _____

III. PARENT/GUARDIAN REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize Oak Grove School to administer medication to my child _____ at school or during overnight school-sponsored activities in accordance with the physician's written authorization as set forth in Part I and Oak Grove School policy. I, or an adult representative, shall bring all medications to Oak Grove School in the original pharmacy containers labeled with my child's name, the physician's name, the name of the medication, and directions for use. I will also provide Oak Grove School with any supplies and/or equipment necessary to administer the medication. In addition, I will provide Oak Grove School a new Medication Authorization form, completed by a physician and parent/guardian, if there is a change in my child's medication, health status, or physician. I understand that I may rescind my consent for administration of medication at school at any time by providing Oak Grove School notice of this rescission in writing. I understand that medications must be picked up by a parent/guardian by the last day of the school year or they will be discarded. As parent/guardian of the above-named student, I hereby hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of Oak Grove School who may act pursuant to the instructions of my child's health care provider.

Signature of parent/guardian _____

Relationship _____ Date _____

IV. PERMISSION TO SELF-ADMINISTER MEDICATION

For example, via EpiPen, asthma inhaler, or diabetes medication. Parts II and III must also be completed.

To be completed by the physician: The above-named student has been instructed in the proper use of their emergency medication. The child's well-being is in jeopardy unless this medication is carried on their person. Therefore, I request that they be permitted to carry the emergency medication at school, as they understand the purpose, appropriate method, and frequency of use of the emergency medication. In my opinion, this student shows the capability to carry and self-administer the medication specified below.

Name of medication _____ Physician's signature _____

Date _____

To be completed by parent/guardian: I permit my child to carry and self-administer the above-listed emergency medication as ordered by their physician. My child is capable of and has been instructed in the safe self-administration of the medication. I understand that my child shall be permitted to carry their medication at all times as long as they do not endanger themselves or endanger other persons or misuse the medication. I understand if my child misuses the medication, or endangers others with the medication, School employees or agents may confiscate the medication. I further understand that Oak Grove School, its employees or agents shall not incur any liability as a result of any injury arising from the administration of the medication by my child. I shall exempt from liability and hold harmless Oak Grove School employees or agents against any and all claims and actions, and all expenses incidental to such claims or actions, based upon or arising out of the self-administration of medication by my child. I understand that this authorization shall be effective for the current school year only and must be renewed annually.

Name of medication _____ Parent/guardian signature _____

Date _____

To be completed by student: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician. I understand that I am required to keep a copy of the physician authorization form and the parent/guardian request and authorization with me at all times. I understand that I am required to talk to a school teacher or administrator if I'm having any problems with my medication, supplies, or equipment, or if I need assistance administering the medication. In addition, I am prohibited from sharing medication with others or administering the medication to others. If I do not use the medication as prescribed by my physician, I understand that Oak Grove School may inform my parent/guardian and revoke my privilege of self-administration.

Student signature _____ Date _____

Reviewed/accepted by _____ Date _____