



STUDENT MEDICATION AUTHORIZATION

In order to administer medication to students during school hours on campus or during off-campus school activities, Oak Grove School requires written authorization from a designated parent or guardian. The parent/guardian must provide all medications in their original containers. This applies to both prescription and over the counter medications. Medications are stored and administered in the front office infirmary (grades 1-8), the high school infirmary (grades 9-12), or the student's classroom (preschool-kindergarten). If a student is to carry and self-administer medication (ex: inhaler or Epipen), a signed agreement from the parent/guardian and student are also required.

Complete the medication information section below, and sign on page 2. For medication that is to be self-administered, sign the agreement on page 3, as well. Submit this form to the Oak Grove School front office with your student's medication.

STUDENT NAME _____ **DOB** _____

Name of medication _____

Prescribing physician _____ **Phone** _____

Medication form: tablet/capsule liquid cream other _____

Dosage amount _____

Medication to be taken: as needed daily at _____ am / pm

Allowable frequency of administration _____

Symptoms necessitating administration _____

Restrictions and/or side effects _____



Student Medication Authorization (Cont.)

I, the undersigned, authorize Oak Grove School to administer medication to my child _____ during school hours on campus or during off-campus school-sponsored activities. This is in accordance with Oak Grove School policy, the physician's written authorization accompanying my child's prescribed medication, and/or parent/guardian authorization accompanying over the counter medication. I, or an adult representative, shall provide all medications to Oak Grove School in their original 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 with a new medication authorization form if there is a change in my child's medication or health status. I understand that I may rescind my consent for administration of medication at school at any time by notifying Oak Grove School either verbally or 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.

Parent/Guardian signature _____ **Date** _____



Permission to Self-Administer Medication

To be completed by parent/guardian: I permit my child _____ to carry and self-administer the medication indicated on this form as ordered by their physician. This medication is to be used only in the event of a life-threatening medical emergency (i.e. anaphylaxis, severe asthma). 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 personnel, employees, and agents may confiscate the medication. I further understand that Oak Grove School, its personnel, employees, and agents shall not incur any liability as a result of any injury arising from the administration of the medication by my child. I exempt from liability and hold harmless Oak Grove School personnel, employees, and agents against any and all claims and actions, and all expenses incidental to such claims and actions, based upon or arising from 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.

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 medication authorization and parent/guardian authorization form 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** _____