AUTHORIZATION FOR PRESCRIBED MEDICATION AT SCHOOL

Date form received by the school: _____

Student: _____Date of Birth _____ Grade:_____

Parent: _____Home Phone _____ Work Phone_____

Homeroom/Teacher: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER				
Name of Medication				
Reason for medication (optional):				
Form of medication/treatment:	Tablet/Capsule	Inhaler	EpiPen/Injection	Nebulizer
Instructions (Schedule and dose to be given at school):				
Start Date:	Date Form Received:		Other date/duration:	
Stop Date:	End of School Year:		Other date/duration:	
For Episodic/emergency events only:				
Restrictions and/or important side effects	No-None anticipated		**Yes**- please describe	
Special storage requirements	None		Refrigerate	Other
This student is both capable and responsible for self-administering this medication	No		Yes-Supervised	Yes-Unsupervised
This student may carry this medication	No		Yes	
Please write all additional information on the back of this form or staple to as an attachment				

Physician's Signature _____ Date _____

Physician's Name: _____ Phone: _____

Address: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I request that _____receive the above medication at school according to standard school policy.
(Student Name)

I request that_____ be allowed to self-administer the above medication at school according to the school policy.
(Student Name)

I hereby release Oakridge Public Schools and district personnel from any liability that may result therein.

Parent/Guardian Signature _____ Date _____

Lower Elementary	Upper Elementary	Middle School	High School	Administration
Phone: 788-7600	Phone: 788-7500	Phone: 788-7400	Phone: 788-7300	Phone: 788-7100
Fax: 788-7614	Fax: 788-7514	Fax: 788-7414	Fax: 788-7314	Fax: 788-7114