OAK HALL SCHOOL
SCHOLARSHIP · LEADERSHIP · SERVICE

REQUEST AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

OTHER MEDICATION

Name of Student: _____ Grade: _____

Address: _____ Date: _____

_____ DOB: _____

_____

Condition for which the medication is needed to be administered during school hours:

_____

Name of Medication *(as appears on bottle)*:_____

Dosage of medication to administer:_____

Method of Administration: _____

Time to be administered: _____

□ Medication will be administered from _____ to _____ (end date)

Relevant side effects to be observed (if any): _____

_____

If there are side effects, plan for management: _____

_____

Authorization by Parent/Legal Guardian of the above medication by school personnel:

I request that the above medication, ordered by the named prescriber for my child, _____, be administered by School Personnel. I understand that I must supply the school with the prescribed medication in the original container and properly labeled by a physician or pharmacist. I understand that any medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of the school year.

Signature: _____ Date: _____

Name *(printed)*: _____ Relationship to student: _____

Phone number(s): Home: _____ Cell: _____ Work: _____