Choctaw Nicoma Park Schools
Medication Request and Release Form

Student: _____ DOB: _____

School: _____ Teacher: _____ Grade: _____

OVER-THE-COUNTER MEDICATION & PRESCRIPTION MEDICATION

TO BE COMPLETED BY THE PHYSICIAN

Fill out and return to school with a NEW UNOPENED CONTAINER of age and dose appropriate medication.

Choctaw Nicoma Park Schools discourages the administration of medication to students in school if possible. This form will only be valid for the current school year. A new form is required yearly.

PLEASE USE A SEPERATE FORM FOR EACH MEDICATION

Medication: _____ Diagnosis:_____
Trade Name and/or Generic

Dosage: _____Time(s) to be given at school: _____

Purpose: _____ Allergies: _____

Special Instructions: _____

Method of Administration: ORAL: ☐ Liquid ☐ Tablet ☐ Inhaler DROPS: ☐ Eye **R L** ☐ Ear **R L**

TOPICAL: ☐ Apply where_____OTHER:_____

Effective Dates: From ____/____/_____ to ____/____/_____

If Medication is PRN (as needed), please specify: _____
Signs and Symptoms

_____Can Medication be Repeated? ☐ Yes ☐ No How many times? _____
Frequency of Administration

_____ _____ _____ ____/____/____

Physician's Name (please print) Physician Signature Physician's Phone Date

****SELF-CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION****
AUTHORIZATION/APPROVAL

Provisions under 70 O.S. 1984, Section 1-1163, allow students to self-administer prescribed asthmatic, diabetic or allergic medication. Approval to self-administer medications must be authorized by the prescribing physician. *The parent/guardian of the student is to provide the school an emergency supply of the student's medication.*

☐ I have instructed_____in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by him/her self.

_____ _____/_____/_____

Physician's Signature Date

FIELD TRIP

A single dose bottle with attached RX label indicating correct dosage information, must be provided to the school. If single dose bottle not provided, child WILL NOT receive medication on field trip day.

TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read the Request and Release Requirements for medication administration and I hereby request and authorize Choctaw Nicoma Park Schools personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless Choctaw Nicoma Park Schools and any of their officers, staff or agents from lawsuit, claim, demand, or action against them for administering medication to this student. I understand permission is granted for exchange of verbal and/or written communication, between the school staff and the prescribing physician/dentist regarding this medication. ***I also understand any remaining medication must be picked up by the legal parent/guardian on or before the last day of school or the medication will be destroyed.***

_____ ____/____/____ _____

Signature of Legal Parent/Guardian Date Contact Phone