School Nurse Reviewed: _____

Altus Public Schools
Permission for Administration Of Medication

For School Use Only:
☐ Routine ☐ Emergency
☐ PRN
Teacher: _____
Start Date: ____/____/_____

When possible, medications should be given to students before or after school by the parent or guardian. Medication will be given to a student only with the written permission of a parent or legal guardian responsible for the student's care. All medications must be provided by and transported to and from the school by a parent or guardian. Over-the-counter medications must be in a new, unopened bottle with the original label listing age-appropriate dosage instructions. Prescription medications must be provided in a currently dated and properly labeled container which correctly states the student's name, prescribing physician's name, and directions for administration. Please note that the school district may reject requests for certain medications to be given at school.

A new form must be completed for each change of medication and renewed each school year.

Student's Name:	Date of Birth: _____/_____/_____	Grade:
Is your child allergic to any food, medicines, or other items? ☐ No ☐ Yes - list allergies:		
Name of Medication (Please use a separate form for each medication):	Time(s) to be given: ☐ _____ ☐ As needed (PRN)	
Specific Reason for medication:	Dates to administer: ☐ _____/_____/_____ to _____/_____/_____	
Amount/Dose of medication to be given:	Possible side-effects, special instructions, etc:	

****TO BE COMPLETED BY LICENSED PHYSICIAN/PRESCRIBER****

Self-Carry / Self-Administration of Emergency Medication (Anaphylaxis, Asthma, & Diabetes Medications)

- This student may carry this medication on their person: ☐ Yes ☐ No
- This student has been instructed, and is both capable and responsible to self-administer this medication: ☐ Yes ☐ No

Prescribing Health Care Provider's Name and Address (please print):	Office Phone Number:
	Office Fax Number:
Provider Signature:	Date:

I hereby authorize Altus Public Schools and its designated employees to administer this medication to my child/student as directed. I give permission for the school nurse and/or designated school employee to contact the above named healthcare provider for medical information relevant to the care of my child/student during school and/or school sponsored activities. I understand that under state law, Altus Public Schools and its employees shall not be liable for any personal injuries to the student which result from acts or omissions of school employees or adverse effects from administering the medication I have authorized, or from the self-administration of medication by my child/student if authorized above. I understand that I am responsible for promptly notifying the school of any changes to my child's health or to the administration of this medication.

Signature of Parent/Guardian Date Emergency Contact Number