Moore Public Schools
Medication Consent Form

uuent: ______________________ School: ______________ Teacher: ______________ Grade: __________

EASE FILL OUT THE FOLLOWING. ALL MEDICATIONS MUST HAVE THE FOLLOWING FILLED OUT BY A PHYSICIAN/NURSE PRACTITIONER/ IYSICIAN'S ASSISTANT.

This form will only be valid for the current school year. A new form is required yearly.
PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

edication: ______________________ Diagnosis: ______________________
Trade name or generic

osage: ______________________ Time(s) to be given at school: ______________________
ethod of administration: __Liquid __Tablet __Inhaler Drops: __Eye R L __Ear R L
opical: __ apply where ______________________ Other: ______________________
fective Dates: From ___/___/_____ to ___/___/_____
ossible side effects: ______________________
medication is PRN (as needed), please specify: ______________________
Signs and symptoms

______________________ Can medication be repeated? ___Yes ___No How many times? __________
Frequency of Administration

______________________ ______________________ ______________________ ______________________
ysician's Name (Please print) Physician signature Physician's phone Date

TO BE COMPLETED BY THE PARENT/GUARDIAN:

ıave read the procedure for medication administration and I hereby request and authorize Moore Public Schools personnel to lminister this medication as directed. I agree to release, indemnify, and hold harmless Moore Public Schools and any of their ficers, staff members, or agents from lawsuit, claim, demand, or action against them for administering medication to this udent. **I understand that *permission* is *granted* for exchange of verbal and/or written communication between school staff and the prescribing physician/dentist regarding this medication.**

______________________ ______________________
gnature of Legal Parent/Guardian Date

CONTRACT FOR EXCEPTION:
TO SELF-ADMINISTER AND RETAIN MEDICATION ON PERSON

*Provisions under 70 O.S. 1984, Section 1-116.3 and the Moore Public Schools Policy #7150 allow a student to self administer a ***prescribed asthma, anaphylactic medication, diabetic medication or replacement pancreatic enzymes***. 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 himself/herself.

______________________ ______________________
Physician signature Date

I understand this request is governed by Moore Public Schools regulations on self-administration of medication and there are conditions and exceptions to self-administration. I have instructed my child to inform school personnel if symptoms persist so additional emergency care can be obtained, if needed. I also understand that this permission may be revoked if my child misuses the medication. I understand that Moore Public Schools, its agents and employees shall incur no liability for any adverse reaction or injury suffered by this student as a result of self-administration.
We, the undersigned, absolve the school of any responsibility in safeguarding our child's medication.

______________________ ______________________
Signature of Legal Parent/Guardian Date

Updated 2/28/2020