ADMINISTRATION OF MEDICATION REQUEST
(1 form per medication per student)

STUDENT NAME: _____________________________ Date of Birth: _______________
STUDENT NUMBER: _________________TEACHER:_______________________

OAKLAND MEADOW SCHOOL

For the safety of all students at our school, these guidelines should be followed:

1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over the counter, must be accompanied by **this form and brought to the school clinic by an adult.**
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. It is the responsibility of the parent/guardian to inform school of any changes and update medication forms. **Medications stored in envelopes, baggies, etc., will not be administered.**
   ALL MEDICATIONS NEED TO BE ADMINISTERED ACCORDING TO DIRECTIONS ON LABEL.
4. **Medications must be picked up at the end of the year, or the school will dispose of them.**

Name of Medication: **Expiration Date:** _ **Reason Medication Given:**

Amount to be Given **Time(s) to be Given:** **Possible Side Effects:** _ **Special Instructions:**

I, ____________________________________, grant permission for the principal or designee to assist in administration of medication listed above for my child, _____________, while at school, or when on field trips.

I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Home: ______________________Work: ________________________ Cell: _________________________

____ ____________________

Signature of Parent Date

===
=

FOR CLINIC USE: □ Medication disposed of By ______________________________ Date ____________

□ Medication picked up By______________________________Date____________

(Parent signature)

MEDICATION RECORD

OAKLAND MEADOW **SCHOOL YEAR:________**

STUDENT:_________ _______________________________GRADE __________________________________
Medication: _____________Dose/Route: _______________________Times to be given:

Record time given and initial. * Sign full signature below. * Codes: A=Absent X=No medication available O=No school today

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUG																															
SEPT																															
OCT																															
NOV																															
DEC																															
JAN																															
FEB																															
MAR																															
APR																															
MAY																															

Initials/Signature		Initials/Signature		Initials/Signature	