Owasso Public School

Authorization To Administer Long-Term Medication

(For medications to be given 14 days or longer)

Student's Name	DOB	Grade/Teacher	School Year

Note to Parents/Legal Guardians:

We attempt to discourage administration of medications during school hours. We request that whenever possible medication be scheduled during non-school hours. Information shall be shared with staff on a "need-to-know" basis. It is the responsibility of the parent/legal guardian to furnish all long-term medications (prescription and over-the-counter).

Medication Requirements During School Hours:

- All medication must be *delivered by the parent/legal guardian* to the school nurse or trained staff.
- The parent agrees to pick up unused medication by the end of the school year or it will be disposed of properly.
- This authorization form must be completed, signed, and given to the school staff prior to receipt of medication.
- A new form must be submitted at the beginning of each school year and any time there is a change in the prescription type, dosage, administration details, etc.
- Prescription medication must be in a container appropriately labeled and dated by the pharmacist. Please ask the pharmacist for a separate bottle/container for school.
- For all medications prescribed for less than 14 days, please complete the Short-Term Medication form.
- *For Epi-Pen and inhaled asthma medications, please complete the Epi-Pen or Inhaled Asthma Medication forms.*

To Be Completed by Parent/Legal Guardian

I, _____, the parent or legal guardian of _____ ("Student") request that the school nurse or, in the nurse's absence, a designated representative, administer the noted medication to my Student. I acknowledge that I have read and understand the Authorization To Administer Long-Term Medication requirements, and I agree to abide by the requirements at all times. I confirm that I have given the first dose of the Student's medication at home. I understand that OPS and its employees, agents, and representatives, shall incur no liability as a result of any injury, side effects, or issues resulting from administration of the medication.

Parent/Guardian'sSignature: _____ Date:_____

To Be Completed by Physician

Student's Name: _____ Diagnosis: _____

Medication	Dosage & Route	Times to be Taken	Special Instructions and/or Side Effects

Physician's Name: _____ Phone Number: _____

Physician's Signature: _____ Date: _____