

**Oldham County Schools**  
**Authorization To Give Prescription or OTC Medication**

If your child requires prescription medication during school hours, or you choose to bring in OTC medication, we **must** have this form completed and signed by the parent/guardian **AND** healthcare provider prior to administering or accepting the medication. This form may be emailed or faxed to the school by the healthcare provider or turned into the school. Any changes to the medication will require a new authorization.

School Year \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Grade: \_\_\_\_\_ Allergies: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER**

1. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Dosing Instructions: \_\_\_\_\_

Specific time to give: \_\_\_\_\_ Route: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

2. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Dosing Instructions: \_\_\_\_\_

Specific time to give: \_\_\_\_\_ Route: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

3. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Dosing Instructions: \_\_\_\_\_

Specific time to give: \_\_\_\_\_ Route: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Phone Date

\_\_\_\_\_  
Print Physician's Name Address

**\*Parent/Guardian must bring prescription medication to the school in a current, original, pharmacy-labeled container. All prescription medicine will be counted upon receipt with parent/guardian and school personnel. OTC medication must be in a small unopened container.**

I hereby authorize school personnel to administer the above medication to my child and release the school, the Oldham County Board of Education and its employees from any liability that may occur from the administering of this medication according to the instructions on this form. Parent/Guardian hereby gives consent to the Oldham County Board of Education and its employees and for the child's physician to discuss his or her medical condition or medication administration referenced above with school or district personnel to assist them in planning for my child's care while at school or school events.

\_\_\_\_\_  
Parent/Guardian Signature Phone Date