

**Moore Public Schools
Medication Consent Form**

Student: _____ School: _____ Teacher: _____ Grade: _____

PLEASE FILL OUT THE FOLLOWING. ALL MEDICATIONS MUST HAVE THE FOLLOWING FILLED OUT BY A PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN'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*

Medication: _____ Diagnosis: _____
Trade name or generic

Dosage: _____ Time(s) to be given at school: _____

Method of administration: ☐ Liquid ☐ Tablet ☐ Inhaler Drops: ☐ Eye R L ☐ Ear R L

Topical: ☐ apply where _____ Other: _____

Effective Dates: From ____/____/____ to ____/____/____

Possible side effects: _____

If medication is PRN (as needed), please specify: _____

Can medication be repeated? ☐ Yes ☐ No How many times? _____
Signs and symptoms

Frequency of Administration _____ Physician's Name (Please print) _____ Physician signature _____ Physician's phone _____ Date _____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

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

Signature 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 _____