



Prescription Medication Permission Form

Student Name: _____

Student DOB: _____

To be completed by Parent/Guardian

- Medical Permission forms must be updated and resubmitted to the clinic before the first day of classes each school year. If a medication dose or administration time changes, the parent/guardian is responsible for updating and obtaining new authorization before submitting it to the Oakwood clinic.
- Medication Permission forms may only be used for ONE medication at a time. Parent/Guardians submitting more than one medication should plan to complete multiple forms.
- **Prescription Medication, including refills, must arrive at the clinic in the new, unexpired, container directly from the pharmacy.** We recommend you request the pharmacist split the medication into two bottles (one for home and school).
- Authorized Oakwood staff members will not administer medication outside of the framework of the documented recommendations authorized for use by a licensed prescriber.
- In the event a medication expires during the school year, a parent/guardian will be notified and must pick up the expired, unused, portion of the medication. Medication that is not claimed will be destroyed in accordance with FDA regulations and recommendations.

Please document the most recent date this medication was administered: _____ Initial: _____

(Oakwood policy states that the first dose of any medication must be given at home and a student should be monitored to determine there is no adverse reaction).

I, _____, the parent/legal guardian of _____, request that the school medication administrator (or designees) administer the following medication to my child during the school hours at the times and dosage indicated. **I agree to provide the medication in the original container supplied by the pharmacy with the label intact.** I understand and accept that Oakwood School staff are not responsible for any effects of the medication administered to my child.

Parent/Guardian Signature: _____ Date: _____

To be completed by the Licensed Prescriber:

I certify that, in my opinion, it is medically necessary that the medication listed below be administered to _____ during school hours and that this medicine may be administered by school personnel.

Medication: _____ Reason: _____

Dosage: _____ Route: _____ Time: _____

Duration: 2026 – 2027 School Year Regular Schedule 2026 – 2027 School Year as Needed

Licensed Prescriber Signature: _____ Date: _____

The following is to be completed by authorized Oakwood Staff at medication intake:

	Date	Count	Parent	Staff	Date	Count	Parent	Staff
	<input type="checkbox"/> Both sections completed & signed							
<input type="checkbox"/> Student Name matches								
<input type="checkbox"/> Original Packaging					Medication Pickup Process:			