OAKLAND CHRISTIAN SCHOOL

PERMISSION TO ADMINISTER MEDICATION for SCHOOL YEAR:_____

Prescription and/or non-prescription medication (such as Tylenol, Advil, etc.) administered to a student at Oakland Christian School (OCS)- and/or at OCS school related activities (field trips, retreats, etc.)- require a written request from the parent/legal guardian alongside of a written set of instructions (see below) and signatures from both the physician and the parent/legal guardian. Signatures are legally required. Please complete this form in full. Medication provided for school-use must be in the original container, in a brand new/sealed container if non-prescription, non-expired, and labeled with the proper identifiers (name, grade, DOB, etc.). Medication for school use must be delivered to the school by the parent/legal guardian and counted with school personnel. No pills/medications in baggies or other containers will be accepted. Please give the initial dose of any new non-emergency medication at home; monitor for side-effects. If your student requires Epinephrine and/or an inhaler, please additionally complete a **FARE** form for your student and see specific instructions below (physician signatures are required on both this form AND the **FARE** form). At the end of each school year, medication pick-up is required by parent/legal guardian or medications will be disposed of as required by law.

Student Name: _____ **Birth Date:** _____ **Grade**: _____

Emergency Contact #1:_____ **Phone Number:** _____

Emergency Contact #2: _____ **Phone Number:** _____

Name of Physician(s): _____ **Physician Phone #:** _____

Physician Address: _____ **Fax:** _____

PRESCRIPTION MEDICATION INFORMATION- *VALID FOR ONE SCHOOL YEAR ONLY*

1. Medication Name(s):_____ **Dose**_____

Route: _____ **Time of Administration:**_____ **Start Date:**_____ **(*Valid for one school year ONLY*)**

Reason for Medication: _____ **Reactions/Side Effects:** _____

2.Medication Name(s):_____ **Dose:**_____

Route: _____ **Time of Administration:**_____ **Start Date:** _____ **(*Valid for one school year ONLY*)**

Reason for Medication: _____ **Reactions/Side Effects:** _____
(Field

***Physician certifies the student named above requires the above indicated medication(s) administered during school hours or school related activities.**
***Physician certifies administration of non-prescription medications as necessary for field trips/retreats as permitted by parents/guardians.**

Date: _____ **Physician Printed Name:** _____ **Physician Signature:** _____
***PHYSICIAN:** If student requires Epinephrine &/or an Inhaler, and an additional EpiPen or Inhaler is required for bus transportation, field trips, or other activities, please provide an extra prescription to the parent. **These students with asthma and/or allergies, additionally require completion of the FARE- Food Allergy Research & Education- form to accompany this form; physician signature is REQUIRED both here and on the FARE form. ***

SELF-POSSESSION/SELF-ADMINISTRATION AUTHORIZATION for Epinephrine &/or Inhalers ONLY- *VALID FOR ONE SCHOOL YEAR ONLY*

Students may possess/carry and/or self-administer emergency medication below ONLY if authorized by the physician and parent/legal guardian.

This student is capable of ☐ **self-carrying** ☐ **self-administering:** ☐ **Epinephrine** ☐ **Inhaler**

Physician Signature for student self-carry/administration of EpiPen/Inhaler: _____ **Date:** _____

Parent/Legal Guardian Signature for child to self-carry/administer EpiPen/Inhaler_____ **Date:** _____

A student's authorization to possess and self-administer medication may be limited or revoked by the building principal after consultation with the school nurse and the student's parents/guardian if the student demonstrates an inability to responsibly possess and self-administer such medication. Please contact the building principal to develop a care plan to address how to keep a record of administration and when the student must seek assistance.

PARENT/LEGAL GUARDIAN AUTHORIZATION

I hereby request that my child be administered medication at school, by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuation of this medication(s) by completing a new form. I consent and authorize the healthcare provider staff and school to share information as needed to clarify orders and assist with my child's healthcare needs. I agree that information contained herein shall be shared with individuals and staff that need to know.

Parent/Legal Guardian Printed Name:_____ **Date:** _____

Parent/Legal Guardian Signature: _____