**Oxford Community Schools**
**Permission for Prescribed Medication at School**

Student Name_____

School_____ School Year _____

Grade_____ Age_____ Date of Birth_____

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## Physician or Licensed Prescriber Authorization

*Only one medication order per form*

Name of Medication _____ Dose_____ Route_____

Reason for medication_____

**For inhalers or other emergency medication only**, it is my professional opinion that this student is responsible and knowledgeable about the proper use of this medication and should be allowed to self-carry. **YES NO**

***In an emergency the student may require help with administration of medication.***

Start or Effective Date, upon delivery of medication and permission to school. **YES NO**
Stop Date at the end of the current school year.

Other Start Date _____ Other End date _____

Routine time(s) to give during the school day _____

Episodic/Emergency use only **YES NO**

Other administration instructions_____

Storage instructions_____

Possible side effects/adverse reactions
_____

**Physician/Licensed prescriber _____**

**Phone Number**_____ **Fax number**_____

**Signature**_____**Date**_____

**Parental Permission**

I request that school staff give my child the above medication as ordered. I give permission for the prescriber to be contacted by school staff about this order if clarification is needed.

**Parent/Guardian**_____**Date**_____
*Signature*

**Phone Number**_____

*Medication should be in the original labeled container. It is the parent/guardian responsibility to: replace expired medication; provide refills when needed; transport the medication to & from the school office.*