St. Pius X School

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

Dear Parent or Guardian:

Medication will be given to a student only with the written permission of either parent (if both parents have legal custody), or the parent/person having legal custody, or the student's legal guardian.

Prescription medicine must be in the currently dated prescription bottle that correctly states the name of the patient, the name of the physician, and directions for administration. Non-prescription medicine must be in the properly labeled container with instructions for administration.

Oklahoma law provides that the school nurse, administrator, or other designated school employee shall not be liable to the student or parent/guardian of the student for civil damages for any personal injuries to the student which result from acts or omissions of the school nurse, administrator, or other designated school employee in administering any medicine pursuant to the provisions of the law except for acts or omissions constituting gross, willful, or wanton negligence.

TO BE COMPLETED BY PARENT OR GUARDIAN

I request that the school nurse, or in her absence, an administrator or other designated school employee, to administer the medication described below to my child. I understand that it is my responsibility to furnish this medication.

Student's Name________________________________ Date of Birth________________

Name of Medication________________________ Dosage: Amount to be given____________

Time to be given______________ Reason for Medication_________________________

If medication is for treatment of an underlying medical condition, please fill out the ***Medical Condition Form***.

Is this a controlled drug: yes no (***controlled drugs cannot be transported by a minor***)

Prescribing Physician______________________________ Phone #________________

Other medications the student is taking:____

Signature of Parent/Guardian_________________________________ Date__________

Relationship________________________ Emergency Phone #____________________

For inhaled asthma medications and anaphylaxis medications only:

Preferred location of medication: office backpack

(continued on back)

Self-administration permitted? yes no

*If yes, I confirm that the student has been diagnosed with asthma and/or anaphylaxis, is capable of and has been instructed in the proper method of self-administration of medication.

Physician's Signature______________________________ Date______________

Printed Name______________________________

*If yes, I acknowledge that the school district and its employees/agents shall incur no liability as a result of any injury arising from self-administration of medication by the student.

Signature of Parent/Guardian______________________________ Date______________

Relationship____________________ Emergency Phone #____________________

This form is to be updated every year per diocesan and state guidelines, or more frequently whenever changes occur.