OAKDALE ACADEMY
AUTHORIZATION TO ADMINISTER MEDICATION

Permission form for Prescribed Medication and Over-the-Counter Medication. This authorization is valid for the ***current school year only***.

OVER-THE COUNTER MEDICATION

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student: ____ Date of Birth: ________________ Grade: _____________

I request that (name of student) ___________________________ receive over-the-counter medication at school according to standard school policy.

☐ Ibuprofen (Motrin) _____ mg. ☐ Acetaminophen (Tylenol) _____ mg. ☐ Benadryl _____ mg. or mL. ☐ Other____________ mg.

_____________________ ____

Date Parent/Guardian Signature

PRESCRIPTION MEDICATION

A separate form is required for each prescription medication.
Prescriptions should be delivered in their original container.

TO BE COMPLETD BY THE PARENT/GUARDIAN:

Student: ____ Date of Birth: ________________ Grade: _____________

I request that (name of student) ____________________________ receive the medication specified below at school according to standard school policy. I understand the parent is required to deliver medication to school.

_____________________ ____

Date Parent/Guardian Signature

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER (for prescriptions only):

Name of medication: ____

Reason for medication (optional): ____

Form of medication/treatment:

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other:________________________________

Instructions: (Times and dose to be given in school): ____

Start: Date form received______________ Other date:__________________________________

Stop: End of school year ______________ Other date/duration:____________________________

Stop: End of summer program__________

Restrictions and/or adverse reactions:

☐ None anticipated ☐Yes. Please describe: ____

____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other:____

PLEASE PRINT:

Physician's Name: ______________________________ Address:_______________________________ Phone:____________________

Physician's Signature:____ Date: ______________________________

Office Use Only
Date received: _________ Received by: ___________________ Administrative approval: _________________________