ONEIDA BAPTIST INSTITUTE

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Permission to Administer Prescribed Medication

Prescribed medications require a prescription from an authorized healthcare professional. This form is required before prescribed medications can be administered at school or in the dormitory. This form is kept on file at the school and will remain effective for the school year indicated. This form must be signed by a physician and renewed each school year.

Student's Name: _____ **DOB:** _____ **School Year:** _____

1. Name of Prescribed Medication_____

Reason for Medication_____

Form of Medication/Treatment ❑ Tablet/Capsule ❑ Liquid ❑ Inhaler ❑ Injection ❑ Nebulizer

❑ Other_____

Describe schedule and dose to be given at school_____

_____

Starting Date ❑ Date Form Received ❑ Other, as specified_____

Stopping Date ❑ For Episodic/Emergency Events Only ❑ End of School Year

❑ Other Date/Duration_____

Restrictions and/or Important Effects* ❑ Yes, please describe_____

**NOTE: In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, she/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.*

Special Storage Requirements ❑ None ❑ Refrigerate ❑ Other_____

Student is capable of/responsible for self-administering this medication ❑ No ❑ Yes

Student must carry this medication on his/her person ❑ No ❑ Yes**

***A student may be permitted to carry medication that has been prescribed or ordered by a physican to stay on or with the pupil due to a pressing medical need. Provided the parent/guardian and physician files the written statement/authorization each year as required by law, a student under treatment for asthma shall be permitted to self-administer medication.*

(continued on reverse)

Permission to Administer Prescribed Medication—Page 2

Student's Name: _____ DOB: _____ School Year: _____

2. Name of Prescribed Medication_____

Reason for Medication_____

Form of Medication/Treatment ❑ Tablet/Capsule ❑ Liquid ❑ Inhaler ❑ Injection ❑ Nebulizer
❑ Other_____

Describe schedule and dose to be given at school_____

Starting Date ❑ Date Form Received ❑ Other, as specified_____

Stopping Date ❑ For Episodic/Emergency Events Only ❑ End of School Year
❑ Other Date/Duration_____

Restrictions and/or Important Effects* ❑ Yes, please describe_____
**NOTE: In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, she/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.*

Special Storage Requirements ❑ None ❑ Refrigerate ❑ Other_____

Student is capable of/responsible for self-administering this medication ❑ No ❑ Yes

Student must carry this medication on his/her person ❑ No ❑ Yes**
***A student may be permitted to carry medication that has been prescribed or ordered by a physican to stay on or with the pupil due to a pressing medical need. Provided the parent/guardian and physician files the written statement/authorization each year as required by law, a student under treatment for asthma shall be permitted to self-administer medication.*

PLEASE READ THE FOLLOWING AND SIGN BELOW

I give permission for the above named-medication(s) to be administered to my student, _____ according to the standard school policy and expressly hold harmless and waive any liability on behalf of the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication(s) unless such is the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____ _____
Relationship to Student Phone Number

I have reviewed the instructions for the prescribed medication(s) named on this form for the above-named child.

PHYSICIAN'S SIGNATURE:_____ **DATE:**_____

PHYSICIAN'S NAME:_____

ADDRESS:_____

PHONE #:_____ EMAIL:_____