Eufaula Public Schools

1705 W.J.M. Bailey Hwy.
Eufaula, OK 74432
(918)-689-2682 Fax (918)-689-1067

Medication Request and Release Form

Student: _____ School: _____ Teacher: _____

OVER-THE-COUNTER MEDICATION TO BE COMPLETED BY THE PARENT

Fill out and return to school with a **New Unopened Container** of age and dose appropriate medication

Medication: _____ Dosage: _____
Purpose: _____ Time(s) to be administered: _____
Dates to be given: _____ Allergies: _____
Special Instructions: _____

PRESCRIPTION MEDICATION TO BE COMPLETED BY THE LICENSED PRESCRIBER

Eufaula Public Schools discourages the administration of medication to students in school if possible. This form will only be valid for the current school year. A new form is required yearly.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Medication: _____ Diagnosis: _____
Trade Name and/or Generic

Dosage: _____ Time(s) to be given at School: _____
Method of administration: ORAL ___Liquid ___Tablet ___Inhale DROPS __Eye R L __Ear R L
Effective Dates: From____/____/____ to ____/____/____
Possible Side Effects: _____
If medication is PRN (as needed), please specify: _____
Signs and Symptoms

_____ Can Medication be Repeated?
Frequency of Administration

_____ _____ _____ _____
Licensed Prescriber's Name (Please Print) Licensed Prescriber's Signature Phone Number Date

**** SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**

Provisions under 70 O.S. 1984, Section 1-1163, allow students to self administer prescribed asthmatic, diabetic, or allergic medication. Approval to self- administer medications must be authorized by the Licensed prescriber. **The parent or guardian of the student is to *provide the school an emergency supply* of the student's medication.**

___I have instructed _____ in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.

_____ ____/____/____
Licensed Prescriber's Signature Date

TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read the attached procedure for medication administration and I hereby request and authorize Eufaula Public Schools personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless Eufaula Public Schools and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering medication to this student. **I understand that *permission is granted* for exchange of verbal and/or written communication between the school staff and the licensed prescriber regarding this medication**

_____ ____/____/ _____
Signature of Legal Parent/Guardian Date Contact Phone