Oxford Community Schools
Permission for Prescribed Medication at School

Student Name_____

School_____ School Year _____

Grade_____ Age_____ Date of Birth_____

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.
Stop Date at the end of the current school year. ☐ **YES** ☐ **NO**

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.