

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY
DESIGNATED SCHOOL PERSONNEL AND EMERGENCY TREATMENT
INFORMATION**

Student Name _____ DOB _____

Home Address _____ Phone # _____

School: HS MS Elem. Grade _____ Teacher _____

Oklahoma law states that the school nurse, administrator or other designated school employee shall not be liable to the student, parent or guardian of the student for civil damages for any personal injuries to the student which result from omission 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. Medication will be given to a student only with the written permission of a parent, legal guardian or person responsible for the student's care. Designated employees may not administer medications requiring invasive routes. Over the counter medications must be in the original packages with printed dosages appropriate for age or weight. Prescription medication must be in a currently dated prescription vial or properly labeled container, which correctly states the student's name, the name of the physician or dentist and directions for administering the medication. Aspirin (acetylsalicylic acid) may only be administered with written permission of the physician or dentist. A new authorization form must be renewed each school year. Medication that is not reclaimed by the last official day of school closing will be destroyed, according to policy. The regulations administering medicines to students are available upon request. Medications will be kept in the school office. Students may not carry prescriptive or non-prescriptive medications on their person (exceptions will be determined by school nurse and Individual Health Plane).

Please list any existing medical conditions and/or instructions, which we need to be aware of including any medication taken on a regular basis: time and amount.

Diagnosis: _____

Medications: _____

Medications: _____

Medications: _____

If there are side effects (plan of management) _____

List allergies or any allergic reactions: _____

Physician/Dentist's name prescribing medications: _____

Office Phone: _____ Emergency Phone: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION, CONT.

Emergency Treatment Information

In case medical emergency treatment is required, Varnum School District will make every effort to contact you or your designee prior to seeking emergency medical treatment, time permitting. Please fill out the following information for making contact in such an emergency.

_____ Home Phone _____ Work Phone _____

Parent or Legal Guardian

_____ Home Phone _____ Work Phone _____

Relative or other designee

_____ Office Phone _____

Physician(s) preferred

Authorization by Parent/Guardian

I fully understand that under State Law, the Board of Education, the School District or employees of the District shall not be liable to the student or student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering medicine whether prescriptive or non prescriptive as described above. I further authorize the school nurse and/or designated school employee to contact the above named physician(s)/dentist(s) for medical information relevant to the care of the student and/or school sponsored activities.

I understand and agree to the terms described above.

Dated this _____ day of _____, 20_____

Parent or Legal Guardian

Current Address

