Oceanside School District
Parent and Prescriber's Authorization for
Administration of Medication in School

A. To be completed by the parent or guardian:

I request that my child, _____, in grade _____, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

I hereby release the school personnel, the Board of Education, and the District of any and all liability arising out of the decision to administer medication, the administration of such medication, and/or any reaction to the medication which may occur to the above-named student.

Signature of Parent or Guardian _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Date _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ Date of Birth _____

Diagnosis _____

Name of Medication _____

Prescribed dosage, frequency, and route of administration _____

_____

Time to be taken during school hours _____

Duration of treatment _____

Possible side effects and adverse reactions (if any) _____

_____

Other recommendations _____

_____

Name of Licensed Prescriber and Title (please print) _____

_____

Prescriber's Signature _____ Date _____

Address _____ Phone _____