OKLAHOMA CHRISTIAN ACADEMY PRESCRIPTION MEDICATION CONSENT FORM

Student: _____ Teacher: _____ Grade: _____

PLEASE FILL OUT THE FOLLOWING. ALL PRESCRIPTION MEDICATION(S) MUST HAVE THE FOLLOWING FILLED OUT PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN'S ASSISTANT

This form will only be valid for the current school year. A new form is required yearly.

PLEASE USE A SEPARATE FORM FOR EACH PRESCRIPTION MEDICATION

Medication: _____ Diagnosis: _____
Trade or Generic Name

Dosage: _____ Time(s) to be given at school: _____

Method of Administration (Please select & add necessary details):

◯ Liquid ◯ Inhaler ◯ Tablet ◯ Topical: Location to Apply _____

◯ Drops: ☐ Eye: __R __L ☐ Ear: __R __L ◯ Other: _____

Effective Dates: From ____/____/____ to ____/____/____

Possible Side Effects: _____

If medications is PRN (as needed), please specify: _____
Signs & Symptoms

_____ Can medication be repeated? ◯ Yes; How often? _____ ◯ No
Frequency of Administration

_____ _____ _____ _____
Physician's Name (Please Print) Signature of Physician Physician's Phone Date

TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read the procedure for medication administration, and I hereby request and authorize Oklahoma Christian Academy personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless Oklahoma Christian Academy 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 prescribing physician/dentist regarding this medication.**

_____ _____
Signature of Parent/Guardian Date

CONTRACT FOR EXCEPTION: TO SELF-ADMINISTER & RETAIN MEDICATION ON PERSON

Certain provisions allow a student to self-administer a **prescribed asthma, anaphylactic, diabetic, or replacement pancreatic enzymes medication.** Approval to self administer medications must be authorized by the prescribing physician. The parent/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.

_____ _____
Signature of Physician Date

I understand this request is governed by Oklahoma Christian Academy regulations on self-administration of medication and there are conditions and exceptions to self-administration. I have instructed my child to inform school personnel if symptoms persist so additional emergency car can be obtained, if needed. I also understand that this permission may be revoked if my child misuses the medication. I understand that Oklahoma Christian Academy, its agents, and employees shall incur no liability for any adverse reaction or injury suffered by this student as a result of self-administration.
We, the undersigned, absolve the school of any responsibility in safeguarding our child's medication.

_____ _____
Signature of Parent/Guardian Date

OKLAHOMA CHRISTIAN ACADEMY OVER THE COUNTER (OTC) MEDICATION CONSENT FORM

Student: _____ Teacher: _____ Grade: _____

PLEASE FILL OUT THE FOLLOWING. ALL OTC MEDICATION(S) MUST HAVE THE FOLLOWING FILLED OUT

This form will only be valid for the current school year. A new form is required yearly.

PLEASE USE A SEPARATE FORM FOR EACH PRESCRIPTION MEDICATION

Medication: _____ Diagnosis: _____
Trade or Generic Name

Dosage: _____ Time(s) to be given at school: _____

Method of Administration (Please select & add necessary details):

○ Liquid ○ Inhaler ○ Tablet ○ Topical: Location to Apply _____

○ Drops: ☐ Eye: __R __L ☐ Ear: __R __L ○ Other: _____

Effective Dates: From ____/____/____ to ____/____/____

Possible Side Effects: _____

If medications is PRN (as needed), please specify: _____
Signs & Symptoms

_____ Can medication be repeated? ○ Yes; How often? _____ ○ No
Frequency of Administration

Medication: _____ Diagnosis: _____
Trade or Generic Name

Dosage: _____ Time(s) to be given at school: _____

Method of Administration (Please select & add necessary details):

○ Liquid ○ Inhaler ○ Tablet ○ Topical: Location to Apply _____

○ Drops: ☐ Eye: __R __L ☐ Ear: __R __L ○ Other: _____

Effective Dates: From ____/____/____ to ____/____/____

Possible Side Effects: _____

If medications is PRN (as needed), please specify: _____
Signs & Symptoms

_____ Can medication be repeated? ○ Yes; How often? _____ ○ No
Frequency of Administration

I consent for my child to be given the following OTC medication(s), at the discretion of Oklahoma Christian Academy personnel, according to the instructions on the package label (please check mark the box(es) desired or the box marked “all the above”):

○ Sunscreen ○ Bug Spray ○ Peppermints ○ Chapstick ○ Aquaphor Ointment ○ Triple Antibiotic Ointment
○ Anti-Itch Ointment/Cream ○ All of the Above

TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read the procedure for medication administration policy, and I hereby request and authorize Oklahoma Christian Academy personnel to administer this (these) medication(s) as directed. I agree to release, indemnify, and hold harmless Oklahoma Christian Academy and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering medication to this student.

_____ _____
Signature of Parent/Guardian Date