Otto-Eldred School District
Parent/Physician Medication Request/Authorization Form

To: Doctor _____

From: Mrs. Templin, School Nurse
O-E Elementary Fax: 814-225-4917
O-E High School Fax: 814-966-3911

Student: _____

Medication to be administered at school: _____
Dosage: _____
Route of Administration:_____
Time to be administered:_____
Duration of Medication Administration:_____
Possible Side Effects: _____
Limitations of specific school activity (sports, gym class, recess, etc.)
_____
Other medications student takes outside of school hours:
_____
Is Student capable of self-administration?_____
If yes, may the student carry medication? (in particular, inhalers or epipens)
_____
Physician Information:
Address: _____
_____
Phone: _____

Physician Signature _____ Date _____

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As parent/guardian of _____, I give my permission for the school nurse or other school personnel to give the medication(s) listed above to my child during the school hours.
Parent/Guardian Signature: _____
Date: _____

Note to parent: An adult must bring the medication to the school in a container with the prescription label from the pharmacist present. <u>Please do not send any unlabelled bottles to school</u>. Any change in the type or dose of medication will require a new request/authorization form to be filled out. Thank you for your assistance.