

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

To: Doctor _____

From: Otto-Eldred School Nurse
O-E Elementary Fax: 814-225-4917
O-E High School Fax: 814-817-4050

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** _____

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. Please do not send any unlabelled bottles to school. 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.