Fax completed forms to: Health Staff Email:

MEDICATION REQUEST AND RELEASE FORM

SECTION 1
PARENT/GUARDIAN COMPLETE FOR ALL MEDICATION

Student Name: Student Date of Birth: M M / D D / Y Y Grade:

School: Teacher:

Allergies:

Reason for Administration:

SECTION 2
PARENT/GUARDIAN - COMPLETE FOR OVER-THE-COUNTER MEDICATION
PRESCRIBING PROVIDER - COMPLETE FOR PRESCRIPTION MEDICATION

Medication: /

Brand Name Generic Name

RX OR OTC Strength: Dosage:

Medication Type : Tablet Liquid Capsule Lozenge Intranasal Inhaler Injection

Route: Time(s) to be given: Daily As Needed (PRN)

If PRN, specify symptoms which indicate administration:

Effective Dates: D D / M M / Y Y TO D D / M M / Y Y OR Duration of School Year

Prescriber's Signature: (required for RX) Date:

Prescriber's Name (Please Print): Prescriber's Phone Number:

SECTION 3
PRESCRIBING PROVIDER - COMPLETE FOR SELF-CARRY/SELF-ADMINISTRATION

Provisions 70 O.S. 1984, Section 1-1163, allow students to self-administer prescribed asthmatic, diabetic, or allergic medication. Approval to self-administer medications must be authorized by the prescribing physician. The parent/guardian will provide the school an emergency supply of the student's medication.

I have instructed _____ in the proper use of their medication, it is my professional opinion that this student is capable of self-carrying and self-administering the above medication.

Prescriber's Signature: Date:

SECTION 4
PARENT/GUARDIAN - COMPLETE FOR ALL MEDICATION

I have read the Medication Request and Release Requirements on the reverse side of this form and I hereby request and authorize VSH Academy personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless VSH Academy and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering the above mentioned 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 provider regarding this medication**. I also understand that any remaining medication must be picked up by a legal parent/guardian on or before the last day of school or the medication will be destroyed.

Legal Parent/Guardian Signature: Date:

MEDICATION REQUEST AND RELEASE FORM

SECTION 5
MEDICATION REQUEST AND RELEASE REQUIREMENTS

BOE Regulation 4006-5

If it is necessary, that a medication be given during school hours the following requirements must be met:

- Medication will not be administered in school or during school-sponsored activities without a current year Medication Request and Release filled out properly and signed by legal parent or guardian and on file.
- Prescription medication must be ordered or advised by a licensed physician/dentist, and permission is granted for exchange of verbal and/or written communication between the school staff and the prescribing provider regarding this medication.
- Prescription medication must be brought to school in the current original container with pharmacy label intact. The label must have the student's name, name of medication, dosage, and time to be given. Prescribing provider MUST complete and sign/date Medication Request and Release. If the medication is not properly labeled or does not match the Medication Request and Release, it will not be given.
- Parents/guardians may ask the pharmacist for a separate container labeled just for the school time dose.
- Over-the-counter medications must be in an unopened original container. Student's name must be written on the box/bottle, the dosage and frequency to be given must be consistent with label instructions.
- ********Medication cannot and will not be accepted in baggies or envelopes********
- For student's safety; it is recommended that the parent/guardian bring the medication to the school and give directly to Health Services staff.
- The school cannot send medications home with students.
- At the end of the school year, any medication remaining must be picked up by the legal parent/guardian, on or before the last day of school or, the medication will be destroyed.
- By signing the Medication Request and Release, the parent/guardian with legal custody understands that VSH Academy 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 of omissions and/or adverse effect of this medication. The parent/guardian agrees to provide medication and any particulars connected with administering
- medication at their own expense.
  The parent/guardian will promptly notify the school of any change in the administration of this medication
- and will provide the school with new prescription bottle and new Medication Request and Release. Written or verbal changes to medication from parent/guardian cannot be accepted.
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SECTION 6
FOR HEALTH SERVICES STAFF USE ONLY

MRR Reviewed by: _____ **Date:** _____

Health Staff Signature

Medication Received Date: _____ **Quantity:** _____ **Expiration Date:** _____

SECTION 7
MEDICATION PICK UP OR DESTRUCTION

Parent/Guardian signature required for pick-up. Witness signature required for destruction.

All prescription medications must be counted with parent/guardian at pick-up. Any medication destroyed must be counted with witness.

Quantity Picked-Up or Destroyed _____

Date of Pick-Up or Destruction: _____ ☐ **Pick-Up OR** ☐ **Destroy**

Parent/Guardian Signature: _____

Health Staff Signature: _____

Staff Witness Signature: _____