



# Ada City Schools Health Services

324 W. 24th  
Ada, OK 74820  
(580) 310-7283  
(580) 310-7284  
Melanie.Rhynes@adapss.com

## Authorization for Administering Prescription Medication

*Every effort should be made to give medications at home. However, if your child must take a prescription medication at school, compliance with the following instructions is required. First doses will NEVER be given at school.*

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Known Food or Drug Allergies: Yes/No List Allergies: \_\_\_\_\_

This form must be completed by parent/guardian and the student's physician before a prescription medication will be administered.

A new form must be completed for each change in medication and renewed each school year. The pharmacy should prepare a bottle for school with the following information: Child's Name, Medication, Dosage, Frequency, Directions for Administration, Doctor's Name, and Date Filled. Medication not sent in the original bottle or container and properly labeled will **NOT** be given.

### To Be Completed By Parent/Guardian:

*I, the undersigned parent/guardian, request that a designated school employee administer to my child the following medication. I also understand that the nurse may contact the physician as needed and medication information will be shared with school personnel who have a need to know. I must pick up the medication at the end of the year or the medication will be disposed of.*

Medication: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_ Route: \_\_\_\_\_

Time(s) of day to administer: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### To Be Completed By Physicians:

*The above named student is currently under my medical care, and has a medical condition that requires him/her to take a prescription medication daily during school hours.*

Medication: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_ Route: \_\_\_\_\_

Reason/Purpose: \_\_\_\_\_

Directions, including time: \_\_\_\_\_

If medication is PRN, describe indications: \_\_\_\_\_

List significant side effects: \_\_\_\_\_

Length of time medication is to be given: \_\_\_\_\_

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Phone

\_\_\_\_\_  
Date