

# OXFORD SCHOOL DISTRICT

## Prescription Medication Permission Form

- I. A doctor must complete Section A of the Medication Permission Form for medications prescribed:
1. On a daily basis.
  2. "As needed" for treatment of chronic illnesses.
  3. For treatment of emergencies.
- II. Parent/Guardian must complete Section B.
- III. **ALL MEDICATION MUST BE BROUGHT TO THE SCHOOL BY A PARENT/GUARDIAN IN THE ORIGINAL PACKAGING.**

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### SECTION A: PHYSICIAN'S ORDERS

Student's Name \_\_\_\_\_ School \_\_\_\_\_ Date \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

For treatment of: \_\_\_\_\_

Adverse reactions expected: \_\_\_\_\_

Instructed on self-administration \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature                      Print Physician's Name                      Telephone

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### SECTION B: PARENTAL/GUARDIAN CONSENT

Student: \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

I hereby request and authorize you to allow my son/daughter to take:

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

All medications will be administered according to manufacturer's recommendations and may be administered for the duration of a valid prescription.

I release school personnel from liability should reactions result from this medication. I authorize a representative of the school to share information regarding this medication with the above doctor.

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

\_\_\_\_\_  
Date