TULSA PUBLIC SCHOOLS
HEALTH SERVICES

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY DESIGNATED SCHOOL PERSONNEL

Oklahoma law states that the school nurse, administrator or other designated school employee shall not be liable to the students, parent or guardian of the student for civil damages for any personal injuries to the student which result from omission of the school nurse, administrator or other designated school employee in administering any medicine pursuant to the provisions of the law except for acts or omissions constituting gross, willful or wanton negligence.

Medication will be given to a student only with the written permission of a parent, the legal guardian or person responsible for student's care. Designated employees may not administer medications requiring invasive routes. Over the counter medications must be in original packaging with printed dosages appropriate for age or weight. Prescription medication must be in a currently dated prescription vial or properly labeled container which correctly states the student's name, the name of the physician or dentist and directions for administering the medication. Aspirin (acetylsalicylic acid) may only be administered with written permission of the physician or dentist. **A new authorization form must be filled out for each change of medication and renewed each school year**. Medication that is not reclaimed by the last official day of school closing will be destroyed, according to policy. The regulations on administering medication to students are available, upon request.

Student Name_____ Birthdate_____

Home Address_____Telephone _____

School_____Grade_____Emergency Telephone_____

PHYSICIAN OR DENTIST ORDER

Diagnosis Requiring Medication_____

Name of Medication #1_____
Time and
amount to be given_____a.m._____p.m.

Date: From_____To _____

Date of Prescription _____Discontinuation Date_____

Intended Effect of Medication_____
_____

Side effects to Expect_____
to Report_____
If there are side effects, plan of management_____
_____
Is this a controlled drug?_____
(controlled drugs cannot be transported by a minor)
Physician's/Dentist's
Name (Type or Print)_____

Office Phone_____Emergency Phone_____

Address_____
Physician's/Dentist's
Signature (if required)_____

Diagnosis Requiring Medication_____

Name of Medication #2_____
Time and
Amount to be given_____a.m._____p.m.

Date: From_____To_____

Date of Prescription_____Discontinuation Date_____

Intended Effect of Medication_____
_____

Side effects to Expect_____
to Report_____
If there are side effects, plan of management_____
_____
Is this a controlled drug?_____
(controlled drugs cannot be transported by a minor)
Physician's/Dentist's
Name (Type or Print)_____

Office Phone_____Emergency Phone_____

Address_____
Physician's/Dentist's
Signature (if required)_____

AUTHORIZATION BY PARENT/GUARDIAN for the administration of the above medication by school personnel:
I hereby authorize Tulsa Public Schools and its designated employees to administer to my child lawfully prescribed medication in the manner described above.
I ACKNOWLEDGE THAT IT MAY BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I acknowledge and agree that I waive any claims that I might have against the School District, its employees and agents arising out of the administration of said medicine. I agree to hold harmless its designated employees from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, attempts at administration or omissions of said medicine pursuant to the provisions of Oklahoma law, except for acts or omissions constituting gross, willful, or wanton negligence. **I further authorize the school nurse and/or designated employee to contact the above named physician(s)/dentist(s) for medical information relevant to the care of the student during school and/or school sponsored activities.**

Signature of Parent/Legal Guardian
or Person Responsible for Student's Care_____Date_____

Relationship to Student_____Address_____

Home Phone_____Emergency Name_____

Work Phone_____Emergency Phone_____

(see back for additional forms on transporting medication/medical equipment and self-administration of medication)

PARENT/LEGAL CUSTODIAN REQUEST
FOR DESIGNATING OWN MINOR CHILD(REN) TO TRANSPORT
MEDICATIONS*/MEDICAL EQUIPMENT

The undersigned, the parent(s)/legal custodian(s) of _____ who is enrolled as a student in the _____ grade at _____School, hereby designate my minor child and/or the sibling to bring my child's medication(s) _____ and/or medical equipment _____ to the school health clinic.

***Ritalin and other controlled substances must be transported by an adult.**

_____ _____
Name of Minor Child Relationship to Student

My reason(s) for requesting the exemption is/are as follows:
Remarks:

I understand that by designating my child(ren), I am responsible for any loss, theft, contamination, or inappropriate sharing of the medication(s) and/or medical equipment with other individuals prior to the item(s) reaching a designated staff member of the school. I also understand that if this arrangement creates an undue risk, I will be contacted to review/revise my request.

Date: _____

_____ _____
Parent/Legal Guardian/Person Responsible for Student's Care Parent/Legal Guardian/Person Responsible for Student's Care

_____ _____
Address Address

_____ _____ _____ _____
Nurse's Signature Date Site Administrator's Signature Date

Note: This request shall not extend beyond the current school year

Remarks: _____
_____

CONTRACT FOR EXCEPTION:
TO SELF-ADMINISTER AND RETAIN MEDICATION ON PERSON

Date: _____

_____(Child's name) has been instructed in the proper use of the _____ inhaler. We, _____ (Physician) and _____ (Parent, Legal Guardian, or Personal Responsible for Student's Care), request that _____ (Child's Name) be permitted to carry the medication on his/her person or to keep same in his/her locker or PE locker, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use of the medication.

I understand this request is governed by Tulsa Public Schools regulations on self-administration of medication and there are conditions and exceptions to self-administration. I acknowledge I may receive a copy of this regulation, upon request. Also I have instructed my child to inform school personnel if symptoms persist so additional emergency care can be obtained, if needed. I have also been advised to have my child wear a medical alert bracelet and that this permission may be revoked if my child misuses the medication, including permitting other children to use the medication

I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

We, the undersigned, absolve the school of any responsibility in safeguarding our child's medication.

_____ _____ _____ _____
Physician's Signature Date Signature of Parent/Legal Guardian or Person Responsible for Student's Care Date

_____ _____
Signature of Parent/Legal Guardian or Person Responsible for Student's Care Date

***This request shall not extend beyond the end of the current school year.**
****This contract does not apply to Ritalin or any other controlled substance.**

HD 17 Revised 06/91, 07/94, 06/95, 12/95, 07/99, 08/03