"Engaging Minds, Inspiring Hearts, Pursuing Excellence"
Physician Authorization to Administer Medication

PRESCRIPTION MEDICATION TO BE COMPLETED BY THE PHYSICIAN

McAlester Public Schools discourages the administration of medication to students in school if possible. **This form will only be valid for the 2022-2023 school year. A new form is required yearly.**

Student Name: _____ DOB: _____

Medication: _____
Trade name and/or generic

Dosage: _____ Time(s) to be given at school: _____

Reason for medication: _____

Method of administration: ORAL INHALER DROPS: Eye R L DROPS: Ear R L

Topical: (apply where)_____

Effective date: From _____/_____/_____ to _____/_____/_____

Possible Side Effects: _____

If medication is **PRN** (as needed), please specify for what symptoms: _____

_____

Frequency of Administration_____ Can medication be repeated: Y N How many times? _____

Special instructions: _____

_____

_____ _____
Physician's Name (please print) Physician's Signature

_____ _____
Date Physician's Phone

***********PLEASE SEE BACK SIDE FOR MEDICATION SELF-CARRY RELEASE***********

200 East Adams
P.O. Box 1027
McAlester, OK 74502-1027

Dr. Robert Steeber
Superintendent of Schools

Tel: 918.423.4771
Fax: 918.423.8166
www.mcalester.k12.ok.us

"Engaging Minds, Inspiring Hearts, Pursuing Excellence"

Self-carry/Self-Administration Release

Requires Annual Renewal

Physician Authorization for Self-Carry Medication

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

Please select:

_____Inhaler

_____Epinephrine auto-injector

_____Insulin

I have instructed _____in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.

_____ _____/_____/_____

Physician's Signature Date

Parent Authorization for Self-Carry Medication

I understand that in electing to have my child self-carry their medication that it is my responsibility to provide the school with an emergency supply of the student's self-carry medication to be administered by district personnel if needed. I also understand and agree that the District, its agents and employees shall incur no liability for any adverse reaction or injury the student suffers as a result of self-administration of medication and/or use of specialized equipment.

_____ _____ / ____ / _____

Parent Signature Date

OFFICE USE ONLY

Medication received:

_____ Date:

_____/_____/_____ Time: _____

Staff signature: _____

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