



“Engaging Minds, Inspiring Hearts, Pursuing Excellence”

PARENTAL AUTHORIZATION TO ADMINISTER MEDICATION 2022-2023

****All effort should be made to administer medication at home. However, if your physician feels it's necessary to have the medication administered during school hours, please complete this form. Please note that a new form will be required with any change in the medication, dosage, or timing AND will need to be renewed EACH school year.**

**** In addition, medications MUST be picked up at the end of the school year. Medications will not be carried over from school year to school year. If medications are not picked up within one week of the end of school, remaining medication will be disposed of properly. Thank you.**

Grade: _____ Student's Name: _____ DOB: _____
Last Name, First Name Middle Name

I am the parent or legal guardian of the above student attending McAlester Public Schools.

I hereby give my consent and authorize the school nurse, the school principal, or designated school employee to administer the non-prescription and/or prescription medication listed below.

_____ Administer the following **NON-PRESCRIPTION** medication, which I am supplying to the school in the original container and packaging with the child's name written on the container.

Name of Medication: _____

Dosage: _____ Time to be given: _____ Duration: _____

Medication is to be given for (be specific): _____

_____ Administer the following **PRESCRIPTION** medication which I am supplying the school, with the pharmacy label that includes the student's name, medication, dosage, time or frequency, expiration date, physician and pharmacy.

Name of Medication: _____

Dosage: _____ Time to be given: _____ Duration: _____

I understand that under state law, the Board of Education, the School District, or Employees of the District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administer the medicine I have hereby authorized.

Parent/Guardian signature: _____ Date: _____

(Office Use Only) Medication received _____ Date _____ Time _____ Initials _____