Western Heights Public Schools
Medication Request and Release Requirements

If it is necessary, that a medication be given during school hours the following requirements must be met:

- **Medication will not be administered in school or during school-sponsored activities without a current year Medication Request and Release Form filled out properly and signed by legal parent or guardian.**
- **Prescription medication must be ordered or advised by a licensed physician/dentist, and permission is granted for exchange of verbal and/or written communication between the school staff and the prescribing physician/dentist regarding this medication.**
- **Prescription medication must be brought to school in the current original container with pharmacy label intact. The label must have the student's name, name of medication, dosage, and time to be given. Prescribing physician/provider MUST complete and sign/date the Medication Request and Release Form. If the medication is not properly labeled or does not match the Medication Request and Release Form, it will not be given.**
- **Parents/guardians may ask the pharmacist for a separate container labeled just for the school time dose.**
- **Over-the-counter medications must be in an unopened original container. Student's name must be written on the box/bottle. The dosage and frequency to be given must be consistent with label instructions. ******Medication cannot and will not be accepted in baggies or envelopes******
- **For student's safety; it is recommended that the parent/guardian bring the medication to the school and give directly to Health Services Staff.**
- **The school cannot send medications home with students.**
- **At the end of the school year, any medication remaining must be picked up by the legal parent/guardian, on or before the last day of school or, the medication will be destroyed.**
- **By signing the Medication Request and Release Form, the parent/guardian with legal custody understands that under state law; WHPS Board of Education, Western Heights Public School District, or employees of the District shall not be liable to the student or the student's parents or guardian for civil damages for any personal injuries to the student which result from acts of omissions and/or adverse effects of this medication.**
- **The parent/guardian agrees to provide medication and any particulars connected with administering medication at their own expense.**
- **The parent/guardian will promptly notify the school of any change in the administration of this medication and will provide the school with new prescription bottle and physician order. Written or verbal changes from parent/guardian cannot be accepted.**

Western Heights Public Schools
Medication Request and Release Form

Student: _____ Student Birth Date: _____

School: _____ Teacher: _____ Grade: _____

OVER-THE-COUNTER MEDICATION **TO BE COMPLETED BY THE PARENT/GUARDIAN**

Fill out and return to school with a **New Unopened Container** of age and dose appropriate medication.

Medication: _____ Dosage: _____

Purpose: _____Time(s) to be administered: _____

Dates to be given: _____ Allergies: _____

Special Instructions:

PRESCRIPTION MEDICATION **MUST BE COMPLETED BY PRESCRIBING PHYSICIAN**

Western Heights Public Schools discourages the administration of medication to students in school if possible. Medication label and Medication Request and Release must match. This form will only be valid for the current school year. A new form is required yearly.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Medication: _____/_____Diagnosis:_____
Trade Name **AND/OR** Generic Name

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

Method of Administration: ORAL Liquid Tablet Inhaler DROPS Eye R L Ear R L
TOPICAL: apply where_____ OTHER _____
Effective Dates: From_____/_____/_____ to _____/_____/_____

Possible Side Effects: _____

If Medication is PRN (as needed), please specify: _____
Signs and Symptoms

_____ Can Medication Be Repeated? Yes No How Many Times? _____
Frequency of Administration

_____ _____ _____ _____
Physician's/Provider Name (Please Print) Physician or Representatives Signature Physician's/Provider Phone Date

****SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION****
AUTHORIZATION/APPROVAL

Provisions under 70 O.S. 1984, Section 1-1163, allow students to self-administer prescribed asthmatic, diabetic, or allergic medication. Approval to self-administer medications 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.**

☐ 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

TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read the Request and Release Requirements for medication administration **(on the reverse side of this form)** and I hereby request and authorize Western Heights Public Schools personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless Western Heights Public Schools and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering medication to this student. I understand that *permission is granted* for exchange of verbal and/or written communication between the school staff and the prescribing physician/dentist regarding this medication. **I also understand that any remaining medication must be picked up by legal parent/guardian on or before the last day of school or the medication will be destroyed.**

_____ _____/_____/_____ _____
Signature of Legal Parent/Guardian **Date** **Contact Phone**

Retention: Student Health File – Permanently **WHPS Health Services – Revised 3/17**