School Year: **20___ / 20___**

ODYSSEY Charter School

AUTHORIZATION TO GIVE PRESCRIPTION MEDICATION AT SCHOOL

PARENT MUST SUPPLY ALL MEDICATIONS TO BE ADMINISTERED DURING SCHOOL HOURS

MUST FILL OUT A SEPARATE FORM FOR EACH PRESCRIPTION MEDICATION TO BE ADMINISTERED DURING SCHOOL HOURS

This form must be completed if medication is to be administered during school hours, field trips or during a chaperoned "before" or "after" school activity. Please give all medications at home before or after school hours when possible.

STUDENT NAME: _____ **DOB:** _____ **GRADE:** _____

HOMEROOM TEACHER: _____ **KNOWN ALLERGIES :** _____

I hereby request Odyssey Charter School, through the school health clinic staff or designee, to supervise/assist with administering this medication to my child, according to the instructions contained in the statement below.
I understand that:

- Medications (both prescription and non-prescription) **MUST** be in the original labeled container (no bags, foil, etc);
- Parent/Legal Guardian is responsible for assuring the school receives specific instructions regarding medication usage, including the medication and related equipment;
- The Parent/Legal Guardian is responsible for informing the school of any changes with the medication - new medications or new doses **WILL NOT** be given until a new form is completed;
- All medication should be taken directly to the School Clinic by the Parent and/or Student;
- All unused medication will be properly disposed at the end of this school year if it is not picked up within one week after medication is discontinued;
- School employees will not assume any liability for supervising or assisting in the administration of medication;
- **Completion of this form for Prescription Medication authorizes Odyssey Clinic staff to discuss the medication order/request with the prescribing healthcare provider if indicated and/or needed.**
- **If student self carries & administers rescue inhaler or EPI-Pen, please request additional authorization form from school clinic.**

PRESCRIPTION MEDICATION (TO BE COMPLETED BY PARENT/LEGAL GUARDIAN)

MEDICATION NAME:		CONDITION/ILLNESS REQUIRING MEDICATION:
START DATE:	STOP DATE:	DOSAGE AND TIME(S) OF ADMINISTRATION:

I release Odyssey Charter School employees from any liability associated with administering this medication. **Parent/Legal Guardian authorization signature is needed for ALL prescription medications.**

_____ _____ _____

PARENT/LEGAL GUARDIAN SIGNATURE | **PRINT NAME LEGIBLY** | **DATE**

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PRESCRIPTION MEDICATION (TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER)

MEDICATION NAME:	PRESCRIBED DOSAGE:
POSSIBLE SIDE EFFECTS:	ADMINISTRATION AND OTHER SPECIAL INSTRUCTIONS:
CONDITION/ILLNESS REQUIRING MEDICATION:	

_____ _____ _____

PHYSICIAN'S SIGNATURE | **PRINT PHYSICIAN NAME LEGIBLY** | **DATE**

Office/Contact Number:_____ Fax:_____

This Section to be completed by the School Nurse / Clinic Assistant ONLY

DATE RECEIVED:	MEDICATION NAME:	# OF DOSES:
EXPIRATION DATE:	DATE RETURNED TO LEGAL GUARDIAN:	COMPLETED BY: