Noble Public Schools 2022-2023
Medication Request and Release Form

Student: ______________________________ Student Birth Date: ____________________

School: ______________________ Teacher: ____________________ Grade: ________

OVER-THE-COUNTER MEDICATION

Fill out and return to school with the **Original Container** of age and dose appropriate medication.

Medication: ______________________________ Dosage: ____________________________

Purpose: ______________________________Time(s) to be administered: __________________

Dates to be given: ________________ Allergies: ____________________________________

Special Instructions: ____

PRESCRIPTION MEDICATION

Noble Public Schools discourages the administration of medication to students in school if possible.
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

Dosage: _______________________ Time(s) to be given at School: _________________________

Method of Administration: ORAL: Liquid Tablet Inhaler DROPS: Eye R L Ear R
Circle One:

TOPICAL: Application site:______________________

OTHER:_____________

Effective Dates: From_____/_____/_____ to _____/_____/_____

Possible Side Effects: ____
Signs and Symptoms

If Medication is PRN (as needed), please specify: ____

____________________ Can Medication be Repeated? Yes How Many Times? ________ No
Frequency of Administration

Physicians Name and Phone Number:____________________________________

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**** 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 and I hereby request and authorize Noble Public Schools personnel to administer this medication as directed. I agree to release, indemnify, and hold harmless Noble 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 the 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 Number**

Retention: Student Health File – Permanently **Created on 4/2/2018**