fax back to
918-366-2339

Bixby Public Schools Health Services
Permission for Student to Carry and Self-Administer Medication
(other than inhaled medications)

Student Name _____ DOB _____ Grade _____

To Be Completed by Student

I have read and understand the medication policy on the reverse side of this form. I understand that I am responsible for the safeguarding of the carried medication and I agree to abide by the policy.

Student Signature _____ Date _____

To Be Completed by Parent

I am the parent/guardian with legal custody of the above named student. I have read and understand the medication policy on the reverse side of this form. I request that my child be allowed to carry and self-administer the physician-ordered medication listed below. I understand that the school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I understand that my child and I are responsible for the safeguarding of the carried medication. I agree to provide the school with an additional supply of the medication ordered below, which can be administered by designated school personnel in the event of an emergency.

Parent/Guardian Signature _____ Date _____

To Be Completed by Physician

Student Name _____ Diagnosis _____

Medication Order _____

_____

Note: If ordered, p.r.n. the interval for repetition of the dose must be specified.

Side Effects to Expect _____

I verify I am providing treatment for the above named student and that he/she is capable of, and has been instructed in the proper method of self-administration of the above ordered medication.

Physician's Name _____ Phone _____

Physician's Signature _____ Date _____

BP H-4
Adopted 2007