Oasis Academy
PARENT/GUARDIAN REQUEST FOR MEDICATION ASSISTANCE

SCHOOL YEAR 2016-2017

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____

1. I request that personnel from Oasis Academy assist my child with the medication noted below.
2. I have read and do understand policies regarding medication during the school day as stated in the Student Policy.
3. I request that medication assistance be provided in accordance with the current prescription(s) from a licensed health care provider. I will notify the school if the health status of my child changes or if the licensed health care provider changes.
4. I agree to provide medication containers which have current, accurate pharmacy label in place. If the medication changes in any way I will provide a new label.
5. If the school nurse has any questions regarding the medication, I understand that the parent/guardian, the licensed health care provider, and/or pharmacist will be contacted before the medication is given.
6. Oasis Academy is authorized to send home or destroy the medication upon expiration of the prescription, completion of the medication treatment, or completion of this schoolyear, whichever occurs first.
7. I authorize my child to be photographed for identification purposes. I understand that his photograph will be used for the express purpose of accurate identification during medication assistance.
8. The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed necessary by the schoolpersonnel.

****Please do not fill out this form unless your child is in need of medication during school hours**

*****If your child is in 6th-12th grade they may self-medicate with over-the-counter medication as long as this form is on file with the school according to Oasis Academy Policy**

****** If a student carries medication for self-treatment for Asthma and/or Anaphylaxis this form also needs to be completed and specified that student may carry.**

In consideration of the permission granted to my child or ward by Oasis Academy to take medication during school hours. I hereby release Oasis Academy, its agents and employees from all actions, damages, claims, or demands which I, my child, or my child's heirs, executors, administrators, or assigns may have against Oasis Academy and its employees, administrators, volunteers or agents from all injuries known or unknown which my child may incur by, or arise from, the administration of the **following medication:**

Parent/Guardian Signature: _____Date:_____

Oasis Academy School Personal to complete following section:

Name of medication:	**Dosage:**
Time(s) of administration:	**Route:**
Prescribing Provider:	**Phone #:**
School Nurse Signature:	**Date:**