Oasis Academy

# PARENT/GUARDIAN REQUEST FOR MEDICATION ASSISTANCE

## SCHOOL YEAR __________

Name of Student: ______________________________ Birthdate: ______________

Teacher: ______________________________ Grade: ______________

Licensed Health Care Provider: ______________________________ Phone #: ______________

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 noted on the back of this form.
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 school year, 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. I further understand that he use of a photograph for this purpose is option for the school.
8. The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed necessary by the school personnel.
9. I hereby give permission for exchange of confidential information in the record of my child between the licensed health care provider prescribing the medication and the school nurse.

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, causes of action, 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 mediation: ______________________________

______________________________________________________________

Parent/Guardian Name (Printed) Signature Date

Telephone Number: ______________________________

**OASIS ACADEMY PERSONNEL TO COMPLETE THIS SECTION**

Name of Medication: ______________________ Dosage: ______________________

Time(s) to be Given: ______________________ Purpose: ______________________

Prescribing Licensed Health Care Provider: ______________________________

______________________________________________________________

School Nurse Signature Date Signature of Person Completing This Section Date

**THIS RELEASE EXPIRES AT THE END OF THE SCHOOL YEAR**