OAKDALE CHRISTIAN ACADEMY

Name of Student _____

**PERMISSION TO ADMINISTER MEDICATION- To be completed by parent/guardian on an annual basis.**

In order for school personnel to administer any prescription medication or over the counter medication on a routine basis to students we must have this form completed and signed by either the student's parent/guardian or doctor. Only medication in the original container with clear instructions will be administered to students. All medication will be kept locked up with school personnel unless a doctor authorizes that a student must carry a medication at all times.

**Please list below current medications and purposes.**

| Medication | Dosage | Time of Day | Purpose | Duration |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Potential reactions or side effects (please list medication and potential side effects):

_____

_____

Does the student need to carry any of these medications at all times?

No __ **Yes ___**

Name of Medication _____

Doctor's Signature (if **Yes**) _____

Doctor's Name, Address & Phone Number:

_____

I hereby request school personnel from Oakdale Christian Academy to give the above medication to _____ (student's name).

- **It is the parent's responsibility to make sure that prescription refills are sent to OCA as needed.**
- **Ongoing medications must be monitored by the student's physician.**
- **A new Permission to Administer Medication must be completed with any change in medication.**

Parent Name _____Signature _____Date _____

I give permission to Oakdale staff to administer **over-the-counter medications** to my child to address occasional symptoms such as headaches, cough, congestion, sore throat, or upset stomach and minor injuries.

Parent Name _____Signature _____Date _____