SANKOFA SCHOOL OF CREATIVE AND PERFORMING ARTS
HEALTH SERVICES

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AND/OR EMERGENCY TREATMENT

Oklahoma law states that the school nurse, administrator or other designated school employee shall not be liable to the students, parent or guardian of the student for civil damages for any personal injuries to the student which result from omission of the school nurse, administrator or other designated school employee in administering any medicine pursuant to the provisions of the law except for acts or omissions constituting gross, willful or wanton negligence.

Medication will be given to a student only with the written permission of a parent, the legal guardian or person responsible for student's care. Designated employees may not administer medications requiring invasive routes. Over the counter medications must be in original packaging with printed dosages appropriate for age or weight. Prescription medication must be in a currently dated prescription vial or properly labeled container which correctly states the student's name, the name of the physician or dentist and directions for administering the medication. Aspirin (acetylsalicylic acid) may only be administered with written permission of the physician or dentist. A new authorization form must be filled out for each change of medication and renewed each school year. Medication that is not reclaimed by the last official day of school closing will be destroyed, according to policy. The regulations on administering medicines to students are available, upon request:

Student Name _____ Birth Date _____
Home Address _____ Telephone _____
School _____ Grade _____ Emergency Telephone _____

PHYSICIAN OR DENTIST ORDER

Diagnosis Requiring Medication _____
Name of Medication #1 _____
Time and
Amount to be given _____ a.m. _____ p.m.
Date: From _____ To _____
Date of Prescription _____ Discontinuation Date _____
Intended Effect of Medication _____
_____
Side Effects: To Expect _____
To Report _____

If there are side effects, plan of management _____
_____
Is this a controlled drug? _____
(Controlled drugs cannot be transported by a minor)
Physician's/Dentist's
Name (Type or Print) _____
Signature (if required) _____

Diagnosis Requiring Medication _____
Name of Medication #1 _____
Time and
Amount to be given _____ a.m. _____ p.m.
Date: From _____ To _____
Date of Prescription _____ Discontinuation Date _____
Intended Effect of Medication _____
_____
Side Effects: To Expect _____
To Report _____

If there are side effects, plan of management _____
_____
Is this a controlled drug? _____
(Controlled drugs cannot be transported by a minor)
Physician's/Dentist's
Name (Type or Print) _____
Signature (if required) _____

AUTHORIZATION BY PARENT/GUARDIAN for administration of the above medication by school personnel:
I hereby authorize Sankofa School of Creative and Performing Arts and its employees to administer to my child lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I acknowledge and agree that I waive any claims that I might have against the Charter School, its employees and agents arising out of the administration of said medicine. I agree to hold harmless its designated employees from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, attempts at administration or omissions of said medicine pursuant to the provisions of Oklahoma law, except for acts or omissions constituting gross, willful, or wanton negligence. I further authorize the school nurse and/or designated employee to contact the above named physician(s)/dentist(s) for medical information relevant to the care of the student during school and/or school sponsored activities.

I UNDERSTAND IT MAY BE NECESSARY TO OBTAIN EMERGENCY TREATMENT DURICH SCHOOL HOURS OR AFTER SCHOOL ACTIVITIES WHILE MY CHILD IS ATTENDING SANKOFA SCHOOL OF CREATIVE AND PERFORMING ARTS. I AUTHORIZE THE SCHOOL TO ADMINISTER FIRST AID OR MINOR MEDICAL TREATMENT AS DEEMED NECESSARY. THE SCHOOL WILL ATTEMPT TO CONTACT ME IF EMERGENCY MEDICAL CARE IS NEEDED. IF THE SCHOOL IS UNABLE TO CONTACT/NOTIFY ME IT WILL HAVE MY CHILD TREATED BY A DULY QUALIFIED PHYSICIAN AT THE NEAREST HOSPITAL OR EMERGENCY CENTER. The aforementioned applies to all school sponsored programs.

Signature of Parent/Legal Guardian
or Person Responsible for Student's Care _____ Date _____

Relationship to Student _____ Address _____

Home Phone _____ Emergency Name _____

Work Phone _____ Emergency Phone _____