2023-2024

MEDICATION FORM

STUDENT NAME: ____ DOB: __________________ Fall Grade: _______

Medication Name	Self-Carry *(Yes/No) Epi-Pen Rescue Inhaler Only	Dosage (mg, ml, tablet)	Route (Oral, Inhale, Topical)	Schedule (morning, bedtime, other)	Daily OR As Needed	Reason for taking Medication	Possible side-effects

Requirements:

1. All supplements, medicated ointments, over-the-counter or prescribed medications are considered "medication" at Ojai Valley School
2. Medication will not be dispensed if it is not in its original container. All medication must come in its original packaging with manufacturer label or pharmacy label in English
3. Expired medication cannot be dispensed
4. Back up self-carry medications (ie. asthma inhaler, epinephrine) brought to Health Center
5. Parent & Healthcare Provider have signed this form

Parent Authorization for Dispensing Medication

I request that student be dispensed medication in accordance with the above information by a member or the Ojai Valley School staff. I must notify Health Center staff if the medication is to be changed or stopped. I understand that Ojai Valley School is not legally obligated to dispense medication to student/camper; therefore, I hold Ojai Valley School and its employees free from any and all suits, which might arise out of these arrangements.

*****I request that the student be allowed to SELF-ADMINISTER/CARRY their asthma rescue inhaler/epinephrine injector while at Ojai Valley School with a Healthcare Provider's signature. I waive any claims/damages/causes of action if they suffer adverse reaction or injury out of self-administration. I agree that Ojai Valley School and its employees are to incur no liability as a result of any injury/personal harm arising from the student's medication self-administration.

Parent/Guardian Name: ____
Signature: ____
Phone #: ___________________________ Date: ________________________

Healthcare Provider Section (Signature or Stamp):
Healthcare Provider's Name: ____
Address: ____
Phone #: ______________________________________

Healthcare Provider's Approval Stamp:

Healthcare Provider's Signature: ____________________________________

Date: ____