ADMINISTRATION OF MEDICATION

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any prescribed or over-the-counter medication to a student. Please complete this form and return to the school office.

Name of Student DOB - Grade Homeroom

Address Telephone

Allergies

To be completed by LICENSED PRESCRIBER

In accordance with ORC 3313.713/3313.716 The Licensed Prescriber must provide the following information before a student is allowed to receive medication at school or possess and self-administer an asthma inhaler.

Condition for which medication is administered

Name of medication, dose and route

Time or indication for administration Possible

side effects to be noted/reported

Special Instructions

Effective Date Expiration date of this request

For ASTHMA INHALERS, AND INSULIN PUMPS - In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. YES - (initials) NO (initials)

The followine section is REQUIRED for ASTHMA INHALERS that a student is carrvine and self-administerine. and is QPTIONAL for other medications:

- Instructions to follow in the event medication does not produce expected relief

- Please list possible side effects for a student for which the medication is not prescribed should he/she receive a dose:

Licensed Prescriber Signature Print Name

/ Date Phone Number

To be completed by PARENT/GUARDIAN

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

I. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.

2. Submit to school personnel a written statement when medication has been discontinued.

3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.

4. Cooperate with school personnel in assisting my child to comply with medication administration instructions.

5. All medications must come to school in the original container from the pharmacist.

For INHALERS. AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. - Yes - No - Initials

Parent//Guardian Signature -- / Date Daytime Phone Number

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