Centerville City Schools

PERMIT FOR DISPENSING PRESCRIPTION/NON-PRESCRIPTION MEDICATIONS TO STUDENTS

(In accordance with ORC 3313.713)

Student Information *(Please print)*

Name:	Birth Date:
Student Address:	Phone:
School:	Grade/Teacher:

Parent/Guardian Authorization (All parents to complete)

1. As the Parent / Guardian of this student: I authorize an employee of the school board to administer the prescribed medication at the school and any activity, event, or program sponsored by or in which the student's school is a participant.
2. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
3. I also authorize Centerville City School's registered nurse to talk with the prescriber or pharmacist to clarify medication order.
4. I give permission for this information to be sent to the school via facsimile.
5. Medication can only be accepted by a Centerville City School's nurse **and** with the appropriately completed medication form.
6. I understand that the medication must be in the ***original*** container and be properly labeled with the student's name. If prescription, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration is required.
7. Parent/Guardian must bring medication to the Centerville City School nurse. Students may not bring medications to and from school.

Please contact parent/guardian if_____

Parent/Guardian Name:	Phone #1:	Phone #2:
Parent/Guardian Signature:	Date:	

Physician's Statement

It is requested that the medication named below be administered by school personnel. The administration of this medication for this student cannot be scheduled for other than school hours.

Name of Medication:_____Route:_____
(***One medication per form)***

Dose: _____ Time/Interval:_____

Reason for use:_____

Date administration is to: Begin: _____End: _____
(*end of school year unless otherwise noted*)

Adverse reactions that should be reported to the physician:
For student for which it is prescribed:_____
_____

For the student for which it is ***not*** prescribed who receives a dose: _____
_____

Special instructions:_____

Physician's Name_____ Phone number: _____

Fax number: _____ Emergency number: _____

Physician's Signature: _____ **Date:** _____

***** ORDERS MUST BE RENEWED EVERY SCHOOL YEAR *****

9/2019