POLICY FOR MEDICATION ADMINISTRATION IN SCHOOL
GALLIA COUNTY LOCAL SCHOOLS

Parents must follow these guidelines for all medications (including over the counter medications):

1. The **Medication Authorization form** requesting that prescription medication be given during school hours must be filled out and signed by a physician and signed by a parent or guardian. Forms are available at your child's school or from your medical provider.

Prescribed medication must be brought to school by the parent in a container labeled by the pharmacy with the following clearly stated:

1. Child's Name
2. Physician's Name
3. Name of Medication
4. Dosage to be given
5. Time to be administered

***When having the prescription filled, please ask the pharmacist to give you a second properly labeled bottle for the school. **Medication sent to school in baggies, envelopes, school lunches, etc. will not be administered**. Medication sent with children on the bus will not be administered. Medications will not be sent home with children on the bus.

2. **Over-the counter medications** that are to be given on a regular basis must be brought to the school by the parent in an original container with specific instructions for administration. Over the counter medications can only be given up to 3 times per month without a **Medication Authorization** form on file.

3. The parents or guardian of the child must inform the school nurse of any changes in the child's health status or change in medication.

All medication forms need to be filled out annually. All unused medication, including over-the-counter medication must be picked up by the parent at the end of the school year, or it will be discarded. No medications will be kept for the following school year.

Gallia County Local Schools

4836 State Route 325, Patriot, Ohio 45658

Phone (740) 379-9085 FAX (740) 379-9135

Parental Authorization and Release/Physician's Request for the Administration of Prescription Medication by School Personnel

Student's Name_____ School_____ Grade_____

Address_____ Date_____/_____/_____

Physician's Name_____ Phone_____ #2 Phone_____

Name and Dosage of Medication_____

Time given_____ Length (Begin Date) _____/_____/_____ (End Date) _____/_____/_____

Special Instructions_____

Reactions to report_____ _____

(Physician's Signature)

The above named child is a student in the Gallia County Local School District (GCLSD). We recognize that it is my/our responsibility to administer any medication that my/our child may require during school hours.

I/We hereby authorize and request the GCLSD and any of its designated employees to administer the following drugs or medications to my/our child. I will deliver the medication to school and submit to school personnel a revised statement signed by the prescribing physician if any of the information provided by the physician changes.

It is necessary that the above named student take medication during school hours. I will notify the school if the medication, the dosage or the procedure is to be changed or eliminated. In consideration for the GCLSD and its designated employees administering the prescribed medication to my/our child as I/We are unable to do so during school hours. I/We in behalf of ourselves and our heirs, administrators, executors, successor, assigns and our child do hereby fully and forever release acquit and discharge the CGLSD Board of Education, the board members individually and the employees of said liability, actions, causes of actions, claims, and demands of whatever kind or nature that I/We may have in behalf of myself/ourselves and my/our named child on account of any and all injuries, losses and damages which my child may sustain from the administration the prescribed medication as administered by an employee of the GCLSD.

School personnel approved by the Board of Education are herewith authorized to administer the medication or procedure as instructed by the physician.

I AGREE TO:

1. **Deliver the medication that is to be dispensed in the container which was provided by the prescribing physician/licensed pharmacist.**
2. **Provide written notice to the school by the physician if the medication, dose, or procedure is changed.**

Parent/Guardian Signature _____ Date_____/_____/_____

Signatures of person authorized to administer medication or procedure:

_____ _____ _____/_____/_____

(Signature) (Initial) (Date)

_____ _____ _____/_____/_____

(Signature) (Initial) (Date)