Southwest Licking Local School District

Request for Administration of Prescription and Nonprescription Medication by School Personnel Form

NOT TO BE USED FOR EPINEPHRINE OR INHALERS

Student Name:		**Birthdate:**	
School:		**Grade:**	

- The student's Ohio licensed health care prescriber must complete and sign Section I of this form each school year.
- Parent / guardian must complete and sign Section II of this form each school year.
- This completed form must be on file in the student's health record before prescription or nonprescription medication will be administered by school personnel. A separate form is required for each medication.
- Medication must be in the original container as dispensed by the physician, pharmacist, or manufacturer and will be stored in the school clinic.

I. Prescriber's Section

Prescriber's Name/Title:	
Phone Number:	

This is to certify that the student named above is under my care and should receive the following medication at the following times during the school day:

Medication Name and Strength:	
Dose:	
Time (during school or school activity):	
Severe adverse reactions to be reported to prescriber:	
Special instructions for administration:	
Possible side effects:	
Special storage instructions:	
Starting an ending date of this request:	Start: End:

Prescriber's Signature/Title:	
Date:	
Address:	
Emergency Contact Number:	

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II. Parent / Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued.

I agree to submit a revised Request for Administration of Prescription and Nonprescription Medication by School Personnel Form if any changes are made regarding the above medication.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities.

I consent to communication between the prescribing health care provider or clinic, the school nurse, and school-based health clinic providers as necessary for medical management.

Any medication remaining after 5 days from the last day of school for students will be discarded.

Parent / Guardian Signature:		**Date:**	
Home Address:		**Phone:**	