General Medication Form

Student Information

Student Name			Date of Birth
Student Address			
School	Grade	Teacher	School Year
List any known drug allergies/reactions			

Prescriber Authorization

Name of Medication			
Dosage	Route	Time/Interval	
Date to Begin Medication	Date to End Medication		
Circumstance(s) for Use			
Special Instructions			
Treatment in the event of an Adverse Reaction			
Procedures for School Employees if the Student is Unable to Administer the Medication or if it Does Not Produce the Expected relief			
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 A) To the student for whom it is prescribed (that should be reported to prescriber) B) To a student for whom it is not prescribed who receives a dose			
Other medication instructions Does medication require refrigeration? ☐ Yes ☐ No			
Prescriber Signature	Date	Phone	Fax
Prescriber Name (Print)			

Parent/Guardian Authorization

☐ I authorize an employee of the school board to administer the above medication. ☐ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☐ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☐ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☐ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian Signature	Print Name	Date	#1 Contact Phone
Parent/Guardian Signature	Print Name	Date	#2 Contact Phone