NEW MIAMI LOCAL SCHOOL DISTRICT
SCHOOL MEDICATION PERMIT

(In accordance with Ohio Revised Code 3313.713)
The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This section to be completed by the parent or guardian.

Name of Student: ____ Birthdate: ______________
Student's Address: ____
Student's Grade: ______________ Student's Home Room Teacher: ______________________________
I request school personnel administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility for results of such medication.
Parent/Guardian Signature _______________________________________ Date: __________________
Phone Number During School Hours: ______________________ Other Phone Number: ______________

This section to be completed by the physician.

Medication: ____ Date of authorization: ________________
Dosage: ____
Time(s) to be given: ____
Date to begin: _______________________________________ Date to end: ______________________
Adverse reactions to be reported: ____
____
Special Instructions:
Administration: ____
Storage: ____
Other: ____
Prescribing Physician (print) __________________________ Signature: _______________________
Physician's Phone Number/Address: ____

This section to be completed by school personnel only.

The following school personnel have read this form and are authorized to administer the medication as outlined:
Employee Signature: ____ Date: ________________

Employee Signature: ____ Date: ________________

Employee Signature: ____ Date: ________________