DELAWARE CITY SCHOOLS

PARENTAL/GUARDIAN NOTIFICATION

If your child will be taking medication during the school year, please have the form on the back of this letter completed and returned to your child's school by the first day of school.

The Ohio Revised Code and the School District Policy do not permit the administration of medication until receipt of the *Authorization for Administration Form* is complete and signed by the parent and/or the physician.

Please remember that all medication must be in a pharmacy labeled bottle or the original container (non-prescription medication).

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
(as required by Section 3313.713 Ohio Revised Code)

Name of Student_____ Date of Birth _____

School _____ Grade_____Teacher _____

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. For prescription medications, both the parent's signature and physician's signature are required.
2. For non-prescription medication, please complete the medication information section and sign below.
3. Medication must be provided in the student's label prescription bottle. (The pharmacy may provide an extra bottle for long-term medication). The prescription label must match the instructions from the physician. If it is a non-prescription medication, it must be in the original container.
4. New forms must be submitted after each school year and for each new medication. New forms must be provided when any changes in the original form occur (for example, changes in the dose, time etc.)
5. Transportation of medication to and from school is the parent's responsibility including the recovery of any medication not administered by the school. Medications must be picked up at the end of the school year or will be disposed of by the school.

I verify that this medication must be taken by: _____
Name of Student

Condition for which it is used: _____

Medication	Strength	Dose
_____	_____	_____
_____	_____	_____

Time medication is to be taken _____ Administration Start Date _____ Expiration Date _____

*** Student Self-Administration:** ◯ **Yes** ◯ **No**

Instructions or precautions including possible side effects: _____

Action to be taken if side effects observed: _____

* **Note: Student self-administration can be permitted if it is life threatening to the student and the student is considered sufficiently responsible. Your signature indicates that the child has been instructed on the conditions for which the medication is taken.**

_____ _____
Physician/licensed prescriber signature Date

_____ _____
Physician/licensed prescriber printed name Phone

I request that medication be administered to my son/daughter according to the direction of the physician and/or myself in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when necessary by the school personnel.

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent/Guardian Date

For School Use Only:
Personnel authorized to administer medication: _____
Signature of Building Principal/School Nurse: _____