Prescription Medicine Administration Form

Northmont City Schools
4001 Old Salem Road
Englewood OH 45322

This form is required for each individual prescribed medication. Please make copies as needed.

Name of Student: _____ Date of Birth: : _____

School Building: _____ Grade/Teacher/Team: _____

*I am requesting permission for my student, named above, to use or receive prescribed medication.
*I will assume responsibility for safe delivery of the medication to school.
*The medication must be received by the school in the original package, as dispensed by a prescriber or licensed pharmacist. The label must match the order.
*I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. (You must submit a revised form, signed by the prescriber, if any of the information contained in this statement changes).
*I release and agree to hold the board of education, its officials, and its employees harmless from any and all liability foreseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____ _____
Parent/Guardian signature Date Phone

The School District requires all of the following information be provided before it will administer medication or treatment to the student.

Name of medication*: _____ Dose: _____ Route: _____

Time and frequency to administer medication: Date the administration of the medication is to:

_____ Begin: _____ End: _____

*If medication is a rescue inhaler or Epi-pen, student may self-carry (prescriber to circle one): YES NO

I, the medical provider, have instructed this student in the proper way to use his/her medication, It is my professional opinion that he/she should be allowed to carry and self administer this medication while on school property or at school related events.

Special instructions:_____

Possible reactions that, if they occur, should be reported to the physician:

_____

I am a licensed healthcare professional, authorized to prescribe drugs, and I have prescribed the following medication to the above named student.

_____ _____ _____
Physician's signature Address Phone

***If student can self carry an Epipen, a backup dose of the Epipen is required to be located at the school clinic.**

***If student can self carry an inhaler, there will not be an inhaler available in the school clinic unless parents provide an extra one.**

***Disclaimer: The School District has the right to determine if a medication is appropriate for use in the school environment. This form is valid for one (1) school year.**