Dear Parent/Guardian,

If you know your child will need medication (prescribed and over the counter, including cough drops) or a medical procedure please have a medication administration form and/or Physicans order completed and returned to your child's school building by the first day of school. *If halved pills are ordered, they must be split by the parent.*

The Ohio Revised Code does not permit the administration of medication until the written parental/guardian request and authorization from your child's licensed prescriber have been received.

**Authorizations from previous school years DO NOT carry over, so to follow physician's orders we need a new form for EACH school year.**

Typically, children who need medication can take them before or after school, elimatinating the need for an order to be sent to school.

*Please remember that all medication must be in a pharmacy-labeled bottle or the original container (if non-prescription). Medication must be brought to the school office by an adult and picked up by an adult at the end of the year.

Sincerely,

Nurse Cheyene RN, BSN

(937) 949-1960

Dayton Early College Academy, Inc.

# REQUEST FOR ADMINISTRATION MEDICATION AT SCHOOL

School______________________________ Grade/ Home Room__________

Name of Student______________________________ DOB__________

## PART 1: MEDICATION TO BE TAKEN AT SCHOOL – TO BE COMPLETED BY PHYSICIAN

The above mentioned student is under my care for (Diagnosis)______________________________

Name of Medication______________________________ Doseage and Route__________ Time_____

Administration to begin______________________________ Administration to end______________

Is this medication being prescribed outside the formulary guideline?______________________________

List all other medication this child is taking______________________________

Severe adverse reaction to be reported to the physician______________________________

______________________________

Please list any medication allergies______________________________

Special instructions______________________________

Name of physician______________________________ Address______________

Phone______________________________ Emergency number______________

Physician's signature______________________________ Date__________

## PART 11: TO BE COMPLETED BY PARENT OR GUARDIAN AND RETURNED TO SCHOOL

I request that the above medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the container in which it was dispersed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/ diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

** Signature of parent/ guardian ______________________________ Date__________

Address______________________________

Home Phone______________ Work Phone______________ Cell Phone______________

The school will supervise administration of medication in pill form. The school will assume responsibility for administering unit-dose liquid medication.

++Children who are in foster home placement by an agency that holds custody, the agency must sign.

## PART 111: TO BE COMPLETED BY SCHOOL STAFF

Person(s) authorized to administer medication for this student. Principal should list names.

1)______________________________

2)______________________________

**Nurse Signature______________________________ Date__________

***Principal's Signature______________________________ Date__________

Dayton Early College Academy, Inc.

# REQUEST FOR SELF-MEDICATION FOR ASTHMA INHALERS

School_______________________________________Grade/Home Room_____

Name of Student_______________________________DOB_______________

Address___________________________________________________________

Name of Medication/ Metered Dose Inhaler__________________________

Orders for use (# of puffs, frequency, with/without spacer_________________

Administration start date_________________Administration end date__________

Adverse reactions to report to prescribing practitioner___________________

__________________________________________________________________

Adverse reactions to watch for in unauthorized user______________________

__________________________________________________________________

Procedure to follow in the event the medication/ metered dose inhaler does not produce the expected relief from student's asthma attack__________________________

__________________________________________________________________

Other instructions_________________________________________________

By signing below the physician or other health care provider and parent/ guardian state that it is their request that the child carry the ordered inhaler on their person at school and at school functions; they realize that because the student is self-administering medication, no adult may be aware that the student is experiencing difficulty, preventing adults from responding appropriately in an emergency; and that the child has been fully trained in the use of the inhaler, knows why, how and when to use it properly and will not give the inhaler to any other student.

Prescriber's name_____________________________Phone_________________

Prescriber's signature__________________________Date__________________

Parent/ Guardian name__________________________Phone: Work___________

Home_____________

Parent/ Guardian signature______________________________

Other______________

Nurse's signature______________________________________Date__________

Principal's signature___________________________________Date__________