



## Request for Administration of Medical Care by School Personnel

**Student's name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **School/Grade/Teacher:** \_\_\_\_\_

- The student's Ohio licensed health care prescriber must complete and sign Section I of this form each school year.
- Parent/guardian must complete and sign Section II of this form each school year.
- This completed form must be on file in the student's health record before medical interventions will be administered by school personnel.

### I. Prescriber's Section

Prescriber's name/title (printed): \_\_\_\_\_ Phone: \_\_\_\_\_

This is to certify that the student named above is under my care and should receive the following medical care during the school day.

**Starting date for order:** \_\_\_\_\_ **Ending date for order:** \_\_\_\_\_


Prescriber's signature/title: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Emergency contact #: \_\_\_\_\_

### II. Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medical care to my child in accordance with the specific written order from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of needed supplies and/or equipment to the school clinic and will notify the school immediately if we change our medical provider or the need for these medical orders are discontinued.

I agree to submit a revised *Request for Administration of Medical Care by School Personnel* (form 5335 F3) if any changes are made regarding the above.

I understand this care can only be administered to my child by a school nurse or parent/guardian until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home address: \_\_\_\_\_ Daytime phone: \_\_\_\_\_