Gallipolis City School District

61 State Street

Gallipolis, OH 45631-1131

Phone (740) 446-3211 Fax (740) 446-6433

www.gc.k12.oh.us

Prescription Medication

Dear Parents/Guardians,

We strongly urge that all medications be administered at home whenever possible. Please consult the prescribing physician or nurse practitioner to see if the medications can be administered at times when your child is at home.

Before the school will give your child prescribed medication at school the State of Ohio law (Section 3313.713 O.R.C) requires that:

1. The parent must complete and sign the Medication Authorization Form.
2. The licensed prescriber must complete and sign the provider portion of the form.
3. The completed and signed form must be returned to school BEFORE the medication can be administered at school.
4. The medication must be brought to school, **by a parent or other responsible adult**, in the **original container** labeled with your child's name, the provider's name, the name of the medication, the dose and time it is to be taken. The instructions on the medication label must match the information given by the prescriber on the medication form.
5. Each medication must have a separate form.
6. Any changes in dosage will require new forms to be completed by the prescriber and parent before the new dosage can be given. A new prescription bottle with the correct label must be provided to the school.
7. If liquid medications are prescribed, the parent must provide an accurate measuring cup/spoon.
8. All medication must be kept in the clinic (except for asthma inhalers or auto injector epinephrine, provided appropriate forms have been completed and student requirements have been met).

These policies are for the health and safety of your child. If you have any questions, please contact the school nurse.

Gallipolis City School District Health Services Coordinator
Morgan C.Houck, MSN, RN

PHYSICIAN'S REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

(This section to be completed by the parent or guardian.)

Name of Student ______________________________ Birthdate ______________

Student's Address ____

School District ____________________________ School ________________

Grade _____ Homeroom No. ______ Homeroom Teacher ______________________

PARENT/GUARDIAN AUTHORIZATION FORM

School personnel approved by the Board of Education are herewith authorized to administer the medication or procedure as instructed by the physician.

I request school personnel administer the medication as instructed and agree to:

1. Deliver the medication that is required for dispensation during school hours in the original container which was provided by the prescribing physician or licensed pharmacist
2. Deliver written notification (by the next school day) to the school by a physician if the medication, the dosage, or the procedure is to be changed or eliminated.

Parent/Guardian Signature ______________________________ Date ______________

Telephone No. During School Hours ______________ Other Telephone No. __________

(This section to be completed by the physician.)

PHYSICIAN'S AUTHORIZATION AND INSTRUCTIONS

Physician's Name ______________________________ Date ______________

Physician's Phone ____________________ Emergency Number ______________

Name of Medication to be given ____

Dosage ____

Time(s) Medication is to be given ______________________________________

Length of time Medication is to be given ____________________ to ______________
(beginning date) (ending date)

Special instructions regarding medication _______________________________

List adverse reactions that should be reported to physician ________________

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Physician's Signature ______________________________ Date ______________

[Adoption date: August 6, 1991]

Revised: October 20, 1993
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