

Strongsville City Schools Medication Administration Form

In accordance with ORC 3313.713

A completed form must be provided to the clinic nurse before the student may be administered medication.

Student name	School
Student address	Grade

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize the clinic nurse or person(s) designated to administer medication to my child, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I absolve the Board of Education of the Strongsville City School District, and all of its officers, agents, and employees of any and all liability, which may arise in any way from the administration of medication to my child.

Parent/Guardian name (print)	Parent/Guardian emergency telephone number
Parent/Guardian signature	Date

This section must be completed and signed by the licensed prescriber: must be the signature of a physician or nurse practitioner.

As the prescriber I agree to provide in writing a revised statement if any of the following information changes.

Name of medication	
Dosage of medication and time to be administered	
Reason for medication	
Date medication administration begins	Date medication administration ends (if known)

Possible severe adverse reactions: to the student to which it is prescribed (that should be reported to the prescriber)

Special Instructions

IT IS NOT POSSIBLE TO ARRANGE FOR THIS MEDICATION TO BE TAKEN AT HOME UNDER THE SUPERVISION OF A PARENT, THEREFORE IT MUST BE TAKEN DURING SCHOOL HOURS

Prescriber name (print)	Prescriber emergency telephone number
Prescriber signature	Date