Pickerington Schools

Request for Administration of Prescription Medication by School Personnel Grades K- 12

Physician's Section:

Name of student: _____ is under my care and should receive the following:

Medication name: _____ Dose: _____ Route: _____

Time of day to administer: _____ Diagnosis/reason for medication: _____

Special storage instructions: _____ Specific instructions for administration: _____

Possible side effects: _____

Date to start medication: _____ Date to stop medication: _____

***For Asthma Inhalers*:**

Student has been instructed on proper use of inhaler and is responsible to carry inhaler and self-administer:

☐ Yes ☐ No

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

_____

_____

List any severe reactions that may occur to another student for whom the inhaler is not prescribed should he/she receive a dose of this medication: _____

_____

We request a duplicate inhaler be provided for availability in the clinic.

_____ _____ _____

Physician's Signature Date Telephone

Please complete both sides of this form.

Parent's Section

I hereby release and give my permission to the Board approved personnel to administer the above stated medication to my child. I further acknowledge by signing this form that the school district or its personnel are under no obligation to render assistance in administering medication and do hereby release all Board designated school employees and the Board of Education from liability for damages or injury resulting from either performing or not performing the assistance requested.

I have read and understand the policy for administration of medication.

Name of Student: _____ Date of Birth: _____ School Building: _____

Home Address: _____ Phone: _____

You must complete a new Request for Administration of Prescription Medication by School Personnel Grades K-12 form each school year.

Signature of Parent/Guardian: _____ Date: _____