



**Prescription Medication Administration Form**  
**(for medication to be given daily or as needed at school)**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Circumstances for Use: \_\_\_\_\_

Dosage and Frequency: \_\_\_\_\_

Date to Begin: \_\_\_\_\_ Date to End: \_\_\_\_\_

(Must be renewed each school year or with each change of orders per ORC 3313.713)

Adverse Reactions to be reported to the Prescriber: \_\_\_\_\_

(Per ORC 3317.716 and ORC 3313.718)

Other Special Instructions: \_\_\_\_\_

Student May Carry Emergency Inhaler/Epinephrine ☐ OR Must be kept in the clinic ☐

(Notice to provider: Backup dose of Epinephrine must be kept in the clinic per ORC 3313.718 if student is permitted to self-carry)

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Prescriber Name, Address and Phone Number: \_\_\_\_\_

**TO BE COMPLETED BY THE PARENT/GUARDIAN:**

I grant permission for the prescriber, pharmacist, and school nurse to communicate in regards to this order. I authorize designated personnel of the school to administer/supervise self-administration of the above named medication as instructed. I permit this medicine to accompany my child on field trips and be administered as needed by trained school personnel during these trips. Students may not carry any medicine. I agree to deliver the medication to the school in an unopened, labeled, original container, supply it as needed, and pick it up at the end of the school year.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
PHONE #

**TO BE COMPLETED BY SCHOOL PERSONNEL:**

I hereby acknowledge reading this request and understand its content and content of the board policy.

\_\_\_\_\_  
NURSE SIGNATURE

\_\_\_\_\_  
DATE