

# East Clinton Local Schools

## MEDICATION ADMINISTRATION AUTHORIZATION

Date: \_\_\_\_\_ Student Name: \_\_\_\_\_

\_\_\_\_ New Vienna Elementary  
\_\_\_\_ Sabina Elementary  
\_\_\_\_ Middle School  
\_\_\_\_ High School

Grade: \_\_\_\_\_

School Year: \_\_\_\_\_

Teacher: \_\_\_\_\_

### Physician Request:

The above named student is under my care and needs the following medication:

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

Dosage: \_\_\_\_\_

Route: oral inhaled/inhaler rectal shot topical other: \_\_\_\_\_

Time: \_\_\_\_\_ or before after lunch \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: end of school year or \_\_\_\_\_

*To be renewed at the beginning of each school year.*

\_\_\_\_\_  
Physician Printed Name

\_\_\_\_\_  
Physician Signature

Office Address and phone number:  
Print or stamp

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

New Vienna Elementary  
301 E. Church St.  
New Vienna, OH 45159  
937-987-2448  
937-584-2817 Fax

Sabina Elementary  
246 W. Washington St.  
Sabina, OH 45169  
937-584-5421  
937-584-2817 Fax

Middle School  
174 Larrick Rd.  
Sabina, OH 45169  
937-584-9267  
937-584-2817 Fax

High School  
174 Larrick Rd.  
Sabina, OH 45169  
937-584-2474  
937-584-2817 Fax

## Medication Authorization

### Parent Authorization

I hereby request and give permission to the school nurse, principal, or their designee to administer the above medication to my child. I will submit a revised form if any of the information changes.

\_\_\_\_\_  
Student Name Medication

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time: \_\_\_\_\_

I also agree to:

\_\_\_\_\_ have the Physician's Authorization Request on the front side to be on file at the school.

\_\_\_\_\_ provide the medication to the school in its **original container**, labeled with the child's name, medication's name, dosage, and instructions.

\_\_\_\_\_ update the school with any medication changes.

I have received:

\_\_\_\_\_ the Medication Drop-off and Pick-up Instruction Sheet.

I have received the Medication Administration Form for self-use of:

\_\_\_\_\_ Not Applicable      \_\_\_\_\_ Inhaler      \_\_\_\_\_ Epi-Pen

\_\_\_\_\_  
Date Parent/Guardian Signature

### Disposal of Medication

\_\_\_\_\_ I acknowledge/understand if my child has been withdrawn from the district for three (3) months and I have been contacted three (3) times via phone call regarding medication left at school, the medication will be disposed of.

\_\_\_\_\_ I acknowledge/understand if my child has medication left at school that is not picked up in thirty (30) days after the last day of school, and I have been contacted via Parent Square three (3) times, then the medication will be disposed of.

Medications disposed of \_\_\_\_\_ at \_\_\_\_\_ am/pm  
Date Time

Witness signatures:

\_\_\_\_\_  
Nurse

\_\_\_\_\_  
Principal/Safety Officer