Mason City Schools
Prescription Medication Dispensing Form

(Return the completed form to the Health Services Coordinator in your child's building)

Student Information

Student Name:			Date of Birth:
Student Address:			Student ID#
School:	Grade/Teacher	Team:	School Year:
Drug Allergies/Interactions		Diagnosis for treatment:	

Prescriber Authorization: To be completed by Prescriber/Health Care Provider

Name of Medication:		Strength:
Dosage:	Route:	Time/Interval:
Date to Begin Medication	Date to End Medication:	
Side Effects/Special Instructions:		
A) To the student for whom it is prescribed, treatment in the event of adverse reaction: B) To the student for whom it is NOT prescribed who receives a dose:		
Student to Self Carry Medication?: Yes_____No_____ ***Applies to emergency medications only*** **(epipens,inhalers,seizure medication and Diabetes medication. (ORC3313.718, ORC3313.716, 3313.7117,3313.7115)**		
Student to Self Administer Medication?: Yes_____No_____**("yes" indicates student has been instructed in proper use, expected result and possible side effects of medication.)** ***Applies to emergency medications only.***		
Licensed Prescriber Signature	Date:	Phone:
Licensed Prescriber Name and Address:		

To Be Completed by the Parent/Guardian

I authorize an employee of the board of education or governing authority to administer the above medication. I also agree to the following:

1.I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the school employee or licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order.

2. I agree to submit a revised statement signed by the prescriber to the school's designated nurse provider if any of the information provided by the prescriber changes.

3. I agree that medication form must be received by the school nurse. I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of the drug expiration when appropriate

4. If authorization to self carry an Epipen or emergency seizure medication is completed by the physician/medical authority, the parent must provide a backup dose of emergency medication for the clinic.. Emergency services will be called for Epinephrine or Emergency seizure medication is administered.

5.Location of self carry medication?" Backpack, purse, locker, cubby, lunchbox (circle one)

6. I understand that this medication order expires at the end of the school year.

NOTE: Students may not transport medication unless the physician has completed a written order to carry epinephrine, inhaler, emergency seizure medication.

Parent Signature_____Date_____Phone_____

Medication Inventory Log

Student Name_____Medication:_____School Year_____

Date Received_____Date Entered_ _____Date Returned_____Expiration_____

Date	***Current Amount in School***	***Amount Received in School***	***Total Amount in School***	***Staff Initials***	***Witness Signature***

Staff Signature

Date	***Initials***	***Signature***