PRESCRIPTION Medication Request Form

Athens City School District ❖ PO Box 9 (21 Birge Dr.), Chauncey, OH 45719

Parent/Guardian Request for the Administration of *Prescription Medication* by School Personnel

PHYSICIAN: Please complete the following information.

Name of Student: _____

Name of Drug: _____

Dosage of Drug: _____ Time To Be Given at School: _____

Route of Drug: _____ Expiration Date: _____

Possible Side Effects: _____

Special Instructions: _____

I hereby request and give my permission to authorized school personnel to administer the listed prescription medication to this student who is under my care.

Signature Prescriber: _____ Date: _____

Prescriber Name (Print): _____ Phone Number: _____

If this medication is an inhaler or epinephrine, please check mark all that apply:

- ❏ Epinephrine to be kept in the student's backpack to be available for self-administration. Student has been instructed on use. *Law requires that a backup must be kept in the school office.*
- ❏ Epinephrine to be kept in a locked cabinet at the school office.
- ❏ Inhaler to be kept in the student's backpack to be available for self-administration. Student has been instructed on use. *Please note that a backup must be kept in the school office.*
- ❏ Inhaler to be kept in a locked cabinet at the school office.

PARENT/GUARDIAN: Please complete the following information.

Student's School: _____ Grade: _____ Teacher: _____

Student's Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone (cell): _____ Phone (home): _____ Phone (work): _____

Place of Employment: _____

Additional Informational: _____

I hereby give my permission for authorized school personnel to administer the above medication as directed by the prescriber. I further agree to promptly notify the school if any of the above information changes by completing a new form. I agree to bring the drugs to the school in the *ORIGINAL CONTAINER*, and to make note of the expiration date and promptly replace expired medications. I agree to have an adult deliver medications to the school and will not send them in with my child or on the bus. ***Important note: Medications will not be available on bus routes, unless they are approved for self-carrying by the prescriber (such as inhalers and Epinephrine auto-injectors). It is the parent/guardian's responsibility to ensure their child has their approved self-carry medication.***

Signature of Parent/Guardian: _____ Date: _____

Once completed, return this form to the school's front office or fax to:

Athens HS	Athens MS	East Elementary	Morrison-Gordon Elementary	The Plains Intermediate
740-797-1421	740-594-6506	740-592-2171	740-589-3049	740-797-4432