



REQUEST FOR ADMINISTRATION OF PRESCRIPTION AND NONPRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Student Name: _____ Date of Birth: _____

Student Address: _____

School: _____ Grade: _____ Teacher: _____

- **Section I** must be completed for all medications. A separate form is required for each medication.
- In accordance with Board Policy 5330, "medication" shall include all medicines including those prescribed by a licensed health professional authorized to prescribe drugs and any nonprescription (over-the-counter) drugs, preparations, and/or remedies.
- **Section II** must be completed by the student's State licensed health professional authorized to prescribe drugs ("prescriber").
- **Section III** must be completed and signed by the student's parent/guardian (for prescription and nonprescription).
- Only medication in its original container; labeled with the date, if a prescription; the student's name; and exact dosage will be administered.

I. MEDICATION INFORMATION SECTION

Medication	
Dose/Route	
Time(s) to be given	
Severe adverse reactions to be reported to prescriber	
Special instructions for administration	
Possible side effects	
Special storage instructions	
Start & end date of this request	Start _____ End _____

II. PRESCRIBER'S SECTION

This is to certify that the above named student is under my care and should receive the prescription medication as directed above, during the school day. As a licensed health professional in the State of Ohio, and at the request of this student's parent/guardian, I direct that the above medication(s) be administered as indicated above.

Prescriber's printed name and title: _____

Prescriber's Signature: _____ Date: _____

Address: : _____ Phone: _____

III. PARENT/GUARDIAN'S SECTION

I hereby give permission for my child named above to receive prescription medication administered by designated school personnel in accordance with the specific written orders from our licensed health professional.

I do hereby release the Board of Education and all school employees from any and all liability for damages or injury resulting directly from this authorization.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if the need for this medication is discontinued.

I agree to submit a revised *Request for Administration of Prescription and Nonprescription Medication by School Personnel* if any changes are made regarding the above medication, or if we change our health professional

If this medication is required during district-sponsored overnight activities, I agree to provide a separate dose to trained school staff supervising my child's overnight activities. I agree to submit a revised *Request for Administration of Prescription and Nonprescription Medication by School Personnel* form to include prescriber instructions outside of regular school hours.

I consent to communication between the prescriber or their clinic, the school nurse, and designated staff as necessary for my child's medication management.

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____ Date: _____