



Request for Administration of Nonprescription Medication by School Personnel

Student's name: _____ Birthdate: _____ School/Grade/Teacher: _____

- Parent or guardian must complete and sign this form at the beginning of each school year.
- This completed form must be on file in the student's health record before school personnel may administer nonprescription medication at school.
- **A separate form is required for each medication.**
- Aspirin (because of its association with Reye Syndrome), rectal suppositories, or G/JG tube medications cannot be administered without an Ohio licensed health care prescriber's request. (See form 5330 F1.)
- All nonprescription medication for elementary students is stored in the clinic. Students may not self-carry.
- **Parents must supply student's medication in the original manufacturer's packaging.**

Medication	
Dosage (may not exceed manufacturer's dosage without an Ohio licensed health care prescriber's order. See form 5330 F1)	
Time / circumstances for administration	
Severe adverse reactions to be reported to parents	
Specific instructions for administration	
Special instructions for storage	
Starting & ending date of this request	Start _____ End _____

I hereby request and give my permission for school district personnel to administer this medication to my child in accordance with the specific written instructions listed above. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

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 Nonprescription Medication by School Personnel* (form 5330 F1a) if any changes are made regarding the above medication.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____

Medication Intake / Sign Out

Student name: _____

Medication: _____

Date	Time	Quantity	Initials		Event Description - list INTAKE or SIGN OUT AND additional details (i.e., field trip, med request, med error, wasted etc)	Date Returned	Time Returned	Quantity Returned	Initials Returned	

Month	AUG		SEPT		OCT		NOV		DEC		JAN		FEB		MAR		APR		MAY		JUN	
Discrepancy	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Initials																						

Disposal Directions:
All meds should be returned to parent/guardian of appropriate student. If multiple attempts were made unsuccessfully, please complete the following procedure.
All non-controlled medications should be disposed of in sharps container in the presence of the building administrator or SRO.
All controlled medications should be disposed of in the community prescription drug drop box.
All controlled medication must be disposed of in the presence of two (2) staff members, one of which must be the SRO or an administrator. Both signatures are required.

Date	Medication	Dose	Qty	Manner of disposal	Signature	Signature
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