ADMINISTRATION OF MEDICATION

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any **prescribed or over-the-counter** medication to a student. Please complete this form and return to the school office.

Name of Student _____ DOB _____ Grade _____ Homeroom _____

Address _____ Telephone _____

Allergies _____

To be completed by LICENSED PRESCRIBER

In accordance with ORC 3313.713/ 3313.716 The Licensed Prescriber must provide the following information before a student is allowed to receive medication at school or possess and self-administer an asthma inhaler.

Condition for which medication is administered _____

Name of medication, dose and route _____

Time or indication for administration _____

Possible side effects to be noted/reported _____

Special Instructions _____

Effective Date _____ Expiration date of this request _____

For ASTHMA INHALERS, AND INSULIN PUMPS – In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. YES _____ (initials) NO _____ (initials)

The following section is REQUIRED for ASTHMA INHALERS that a student is carrying and self-administering, and is OPTIONAL for other medications:

- Instructions to follow in the event medication does not produce expected relief _____
  _____
  _____
- Please list possible side effects for a **student for which the medication is not prescribed** should he/she receive a dose:
  _____

_____	_____	____/____/____	_____
Licensed Prescriber Signature	Print Name	Date	Phone Number

To be completed by BOTH PARENTS/GUARDIANS

I give permission for the principal or his/her designee to administer the medication as prescribed above to my son, and further agree to the following:

1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.
2. Submit to school personnel a written statement when medication has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my son's health and treatment issues as they pertain to the above medication/diagnosis and his educational and behavioral management needs.
4. Cooperate with school personnel in assisting my son to comply with medication administration instructions.
5. All medications must come to school in the original container from the pharmacist.

For INHALERS, AND INSULIN PUMPS: It is my opinion that my son understands the use of this medication, demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. _____ Yes _____ No _____ Initials

_____	____/____/____	_____
Parent//Guardian Signature	Date	Daytime Phone Number
_____	____/____/____	_____
Parent//Guardian Signature	Date	Daytime Phone Number

**** THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR