AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

As required by Section 3313.713 Ohio Revised Code

Student Name _____ Date of Birth _____

School _____ Grade / Room _____ Teacher _____

PARENT/GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. *I understand that* both the parent section (TOP) and the licensed prescriber section (BOTTOM) must be fully completed.
2. *I understand that* medication must be provided in the student's labeled prescription bottle. The pharmacy may provide an extra bottle for long-term medication. The prescription label must match the instructions from the prescriber. If it is a non-prescription medication, it must be in the original container.
3. *I understand that* a new form must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.)
4. *I understand a* student may carry this medication **(for emergency use only),** however, you MUST secure Principal's approval.⁂
5. *I understand that* at the end of the school year, it is my responsibility to pick up the remaining medicine or it will be discarded.
6. *I will notify* the school immediately if there is any change in the use of the medication or the prescribed treatment.
7. *I release and agree* to hold the Board of Education, its officials, and its employees, harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. It is not the school's responsibility to remind the student to take the medication. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Signature of Parent _____ Date _____ ⁂Principal's Signature for Emergency Use Only _____

LICENSED PRESCRIBER SECTION

I verify that this medication must be taken by: _____
Name of Student

Diagnosis for which medication is prescribed: _____

Medication _____ Strength _____ Dose/Frequency-(be specific-before or after lunch? / How many hours between puffs?) _____

Time Medication is to be Taken _____ Start Date For Medication _____ Last Date to Administer this Medication _____

Instructions or precautions, including possible side effects: _____

Any additional information: _____

Licensed prescriber signature _____ Date _____

Licensed prescriber printed name _____ Address _____ Phone _____

PP03-107