15181 St. Rt. 58 South
Oberlin, OH 44074
Nurse-440-774-1051 ext.2228
Fax-440-774-6421

ADMINISTRATION OF MEDICATION AT SCHOOL
In accordance with 3313.73, 3313.76 Ohio Revised Code.

School policy requires consent of the parent/legal guardian and a written statement (order) from the licensed prescriber before school personnel can give any medication to a student. All medications including over the counter medication requires a physician/prescriber order. The following information is necessary in order to comply with this policy. **ALL REQUESTED INFORMATION MUST BE COMPLETED IN FULL.**

Please return the completed form to the school office.

STUDENT____________________________________**DOB**_______________**PROGRAM**______________**GRADE**_________
ADDRESS____**TELEPHONE**______________________________

TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER/PHYSICIAN

The above mentioned student is under my care for (diagnosis): ____
Medication, Dosage, and Route ____
At the following times ____
Starting date: _____________________ Expiration date of this request: End of school year _____ Other date _______
Special Instructions: ____
Possible side effects: ____

IF PRESCRIBING AN ASTHMA INHALER OR EPI PEN

*Authorization for Student to Carry Inhaler OR Epi Pen: ______Yes ______No
*Prescriber has determined that the student is capable of possessing and using appropriately: _____Yes _____No
*Prescriber has trained the student in the proper use: ______ YES ______ No
*Any adverse reactions to student or unauthorized user that should be reported to the physician:
____
____
*Procedure to follow in the event that inhaler or Epi pen does not produce relief
____

***If the student is to possess an Epi pen for self injection, a SECOND back up pen MUST be in the possession of the school nurse/staff.** *These are requirements as of March 1, 2007 as per ORC Sec. 3313.718.

X____ ____
Licensed Prescriber Printed name Address

X____ ____________ __________________/______________________
Licensed Prescriber Signature Date Phone Number Emergency Number

TO BE COMPLETED BY THE PARENT/GUARDIAN

MEDICATION MUST COME TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE AFFIXED LABEL FROM THE PHARMACY. THE LABEL MUST SHOW THE STUDENT'S NAME, NAME OF THE MEDICATION, THE DOSAGE DIRECTIONS, THE LICENSED PRESCRIBER'S NAME AND THE RX NUMBER (IF THERE IS ONE.)

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

1. Submit to school personnel a revised statement signed by the licensed prescriber of the above medication when any change in the original statement (order) occurs.
2. Submit to school personnel a written statement when medication, given on a daily or as needed basis, has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child with medication administration instructions.
5. Provide safe transportation of the medication to and from school.

X____ _____________ __________________________________
Parent/Guardian Signature Date Parent Emergency Day Phone Number

Revised 5/15 MKW