Finneytown Local School District

Dispensing Non- Prescription Medications at School

A registered nurse, health aide or other school personnel is available to provide emergency and supplemental care for students. Students often have minor ailments and complaints that prohibit maximum effort in school, but can be eased, with simple over the counter remedies. The nurse or other personnel on duty may also use alternate methods of care (ice packs, rest) when possible.
We require written permission annually from you and your physician for each child, if our nurse/personnel is to give intermittent non-prescription remedies. Students who routinely use certain medications are encouraged to provide their own non-prescription medicine. This medicine will be kept in the nurses office. The medication must be in its original container, unopened and brought in by the parent/guardian.

___ YES, I hereby grant permission for the school nurse, health aide or school personnel to dispense only those over the counter medications, which are checked below. I release the nurse, health aide and school personnel from any liability for the administration of said preparations.

Student Name _____ Grade_____ DOB _____

_____ _____ _____
Parent/Guardian Signature Telephone Number Date

Physician, Please complete the medications you permit:

PAIN RELIEF	DOSAGE	FREQUENCY	INDICATIONS	REACTION
Ibuprofen	_____	_____	_____	_____
Acetaminophen (generic Tylenol)	_____	_____	_____	_____
OTHER				
Sudafed	_____	_____	_____	_____
Halls or Robitussin cough drops	_____	_____	_____	_____
Antacids (Rolaids, Mylanta, Tums)	_____	_____	_____	_____
TOPICALS				
Vaseline	_____	_____	_____	_____
Triple Antibiotic Ointment	_____	_____	_____	_____
Caladryl or Benadryl	_____	_____	_____	_____
Hydrocortisone Cream 0.5 or 1%	_____	_____	_____	_____
Visine Eye Drops	_____	_____	_____	_____
Insect Sting Swabs	_____	_____	_____	_____
Aloe Vera Gel	_____	_____	_____	_____
Sports Cream	_____	_____	_____	_____
OTHER: _____	_____	_____	_____	_____

List any drug allergies: _____
List all routine prescribed medications: _____

Physician Signature/Stamp _____ Date_____

Updated 8/18/15

FINNEYTOWN LOCAL SCHOOL DISTRICT
ADMINISTRATION OF MEDICATION

Form 5330 F1

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any **prescribed** 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 PARENT/GUARDIAN

I give 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, 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 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 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 child understands the use of this medication, demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. _____ Yes _____ No

_____ ____/____/____ _____

Parent//Guardian Signature Date Daytime Phone Number

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