Finneytown Local School District

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 ___________________________________

****The following section is REQUIRED for ASTHMA INHALERS or other MEDICATIONS that a student is carrying and self-administering:For ASTHMA INHALERS, INSULIN PUMPS and PRESCRIBED MEDICATIONS**– 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)

- 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, INSULIN PUMPS AND PRESCRIBED MEDICATIONS: 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 _____ Initials

____ ____/____/____ __________________________

Parent//Guardian Signature Date Daytime Phone Number

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

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 given 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 nurse's office. The medication must be in its original container, unopened and brought in by the parent/guardian.

____ (parent/guardian initials) **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.

To be completed by PARENT/GUARDIAN

STUDENT NAME______________________________________**GRADE**_____________**DOB**__________________________

____
Parent/Guardian Signature **Telephone Number** **Date**

To be completed by LICENSED PRESCRIBER

Physician Please complete the medications you permit:

MEDICATION NAME	DOSAGE	ROUTE	FREQUENCY	INDICATIONS	REACTION (SIDE/EFFECTS)

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

Physician signature/stamp:____ **Date:**________________________

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