BUCKEYE CAREER CENTER

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Please print legibly and complete all areas

I request that medication be administered to my child, ____
Name of Student

____ in accordance with the instructions of our physician.
School Grade Lab

I understand that the administration of said medication is to be done under the supervision of either the principal/director, school nurse, or other responsible person. I also give my permission to the school nurse to communicate with the physician regarding this/these medications.

It is the parent's/legal guardian's responsibility to provide the school with an adequate supply of medications. No more than one week's supply should be provided at any time unless prior arrangements have been made with the school nurse/principal/director.

All prescription medication is to be brought in an original container, with the pharmacy label including the student's name, physician's name, date, pharmacy name and telephone number, name of medication, prescribed dosage, frequency, and specific handling and storage instructions.

I agree to notify the school immediately if I change physicians, the medicine or dosage is changed, or the medication administration is terminated.

As a parent/guardian, you understand that a school employee will immediately request assistance from an emergency medical service provider if epinephrine is to be administered.

ALL MEDICATIONS MUST BE SUPPLIED TO THE SCHOOL IN ITS ORIGINAL CONTAINER

Signature of parent/guardian ____

Address ______________________________ Phone No. ____________________ Date ______________

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONEL

(Student name) ____ is under my care and should receive

1.) ____
Name of Drug Dosage/Route Time

2.) ____
Name of Drug Dosage/Route Time

My specific instructions for administration are: ____

____

Please specify: Student is to carry own inhaler or leave in the clinic for staff administration OR BOTH.
Student is to carry own EpiPen or leave in the clinic for staff administration OR BOTH.

For auto injector or inhaler: as the prescriber, I have determined that this student is capable of possessing and using this auto injector or inhaler appropriately and have provided the student with training in the proper use of the auto injector or inhaler.

Possible side effects ____

Expiration date for this request ____

Date ____________________ Physician's signature ______________________________

Address ______________________________

Phone ______________________________

SCHOOL PRINCIPAL/DIRECTOR'S REQUEST FOR THE ADMINISTRATION OD MEDICATION BY SCHOOL PERSONNEL

Person(s) authorized to administer medication for student (Name)______________________________

Nurse ______________________________ Signature ______________________________ Date ____________________

Teacher/secretary/aide ______________________________ Signature ______________________________ Date ____________________

Principal/director ______________________________ Signature ______________________________ Date _ ____________________

Section 3313.713 Ohio Revised Code (pursuant to AM S.B. 262)_