NORWOOD CITY SCHOOL DISTRICT 2019-20

ADMINISTRATION OF MEDICATION AT SCHOOL

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: _____ HR: _____

ADDRESS: _____PHONE#:_____

ALLERGIES: _____

To be completed by LICENSED PRESCRIBER

In accordance with the ORC 3313.713/3313.716 The Licensed Prescriber MUST provide the following information before a students is allowed to receive medication at school or possess and self-administer and asthma inhaler.

Condition for which medication is administered: _____

Name of medication, dose and route: _____

Time or indication for administration: _____

Specific instructions for administration: _____

Possible side effects to be noted/reported: _____

Effective Date: _____/_____/_____ **Expiration date of this request: _____/_____/_____**

FOR ASTHMA INHALERS, EPI-PENS, 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:

_____

_____

Licensed Prescriber Signature_____ Printed 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 comply with medication administration instructions.
5. All Medications must come to school in the **original container** from the pharmacist.

For INHALERS, EPI-PENS, 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. I further understand that my child will sign a contract stating he/she will be responsible for the medication during school. **YES**_____ **NO**_____ INITIALS_____

_____ _____/_____/_____ _____

Parent/Guardian Signature Date Daytime Phone Number

****THIS FORM EXPIRES AT THE END OF THE 2019-20 SCHOOL YEAR****

Section 504 of the ADA Amendments Act of 2008 ADAAA

Section 504 of the Rehabilitation Act of 1973 requires a public school district to identify each child who has a disability that substantially limits a major life function such as learning, eating, sleeping, etc. If you believe your child's health condition substantially limits a major life function, he/she may qualify for an evaluation to determine Section 504 eligibility. Please feel free to contact the Norwood City Schools' Special Education Coordinator, Joe Miller, at 924-2502 or Norwood City Schools' district nurse, Kathy Strasser at 924-2882.