

Norwood City Schools
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 SCHOOL YEAR****