# NORWOOD CITY SCHOOL DISTRICT 2021-22

## 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 ****

**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, Shannon Eshman, at 924-2502 or Norwood City Schools' district nurse, Jacqueline Fiora at 924-2882.

# NORWOOD CITY SCHOOL DISTRICT 2021-22

## ADMINISTRATION OF MEDICATION AT SCHOOL / ADMINISTRACIÓN DE MEDICACIÓN EN ESCUELA

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.

*La política escolar requiere el consentimiento del guarda paternal/legal y declaración escrita de prescriber autorizado antes de que el personal escolar pueda dar cualquier medicación prescribida o sin receta médica a un estudiante. Por favor complete esta forma y vuelva a la oficina escolar.*

NAME OF STUDENT: _____ DOB: _____/_____/_____ GRADE: _____ HR: _____
*NOMBRE DE ESTUDIANTE*

ADDRESS: _____ PHONE#: _____
*DIRECCIÓN* *TELÉFONO*

ALLERGIES: _____
*ALERGIAS*

### To be completed by LICENSED PRESCRIBER / *Ser completado por PRESCRIBER autorizado*

**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.**

***De acuerdo con la ORCA 3313.713/3313.716 Prescriber autorizado DEBE proporcionar la información siguiente antes de que a unos estudiantes les permitan recibir la medicación en la escuela o poseer y autoadministrar e inhalador de asma.***

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 Signed_____ Phone Number_____

### To be completed by PARENT/GUARDIAN / *Ser completado por PADRE/GUARDA*

Doy el permiso para el principal o su/su persona designada para administrar la medicación como prescribido encima a mi niño, y adelante estar de acuerdo con lo siguiente:

1. Presentar al personal escolar una declaración revisada, firmada por prescriber autorizado del susodicho, cuando cualquier cambio de la declaración original ocurre.
2. Presentar al personal escolar una declaración escrita cuando la medicación ha sido discontinuada.
3. El permiso de subvención para la enfermera escolar para consultar con susodicho prescriber autorizado en cuanto a salud de mi niño y tratamiento resulta cuando ellos pertenecen a la susodicha medicación/diagnóstico y sus/sus necesidades de dirección educativas y behaviorísticas.
4. Cooperar con el personal escolar en la asistencia de mi niño a cumplir con instrucciones de administración de medicación.
5. Todas las Medicaciones deben venir a la escuela en el contenedor original del farmacéutico.

**Para INHALADORES, EPI-PLUMAS, Y BOMBAS DE INSULINA:** Esto es mi opinión que mi niño entiende el uso de esta medicación, demuestra la administración apropiada, y ha mostrado el comportamiento responsable cuando esto viene al transporte de esta medicación. Adelante entiendo que mi niño firmará un contrato que declara él/ella será responsable de la medicación durante la escuela. **SÍ** _____ **NO**_____ INICIALES _____

_____ _____/_____/_____ _____
Firma de Padre/Guarda Fecha Número de Teléfono de Día

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

*****ESTA FORMA EXPIRA AL FINAL de AÑO ESCOLAR*****

**Section 504 of the ADA Amendments Act of 2008 ADAAA**

La sección 504 del Acto de Rehabilitación de 1973 requiere que un distrito escolar público identifique a cada niño que tiene una discapacidad que considerablemente limita una función de vida principal como aprendizaje, comida, dormir, etc. Si usted cree que la condición de salud de su niño considerablemente limita una función de vida principal, él/ella puede tener derecho a una evaluación para determinar la elegibilidad de la Sección 504. Por favor siéntase libre de ponerse en contacto con el Coordinador de Educación Especial de las Escuelas de Norwood City, Shannon Eshman, en 924-2502 o la enfermera de distrito de las Escuelas de Norwood City, Jacqueline Fiora en 924-2882..