SOUTHEAST LOCAL SCHOOL DISTRICT

Health Services

Primary Clinic 330 654 1937 Fax 330 654 9110

Authorization for the Administration of Medication by School Personnel
As required by Section 3313.713 Ohio Revised Code

Student Name ______________________ Date of Birth ______________

Address ______________________

School ______________ Grade ________ Teacher ______________

Parent/ Guardian Section

Please review the following steps required for permission of school personnel to administer any medication to your child.

1. Written Permission from the physician to dispense medication at school

2. Written permission from a parent to dispense medication at school

3. Medication must be provided in the student's labeled prescription bottle. The prescription label must match the instructions from the prescriber. Over the counter medication must be in a new unopened bottle/package.

4. New forms must be submitted each school year and for each new medication. New forms must also be submitted when any changes occur in the original form (for example, changes in the dose, time, stopping medication, etc.)

**** In order for a student to carry an Epipen or inhaler the student must have this form filled out by the physician with an order for self-administration and a parent signature.****

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between this healthcare provider and school regarding this medication order when deemed necessary by school personnel.

I authorize the school to appoint a qualified delegated person(s) to give the prescribed medication/treatment as directed by the physician order.

I also understand and agree to hold the school district and its employees free from all responsibility for the results of such medication and that no employee is liable in civil damages for administering or failing to administer the medication/treatment.

Signature of Parent ______________________ Date ______________

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LICENCED PRESCRIBER SECTION

I verify that this medication must be taken by

____
Name of Student

For

____
Diagnosis for which medication prescribed

____
Medication Name Strength Dose

____
Time medication to be taken Administration Start Date End Date

____
Instructions or precautions, including possible side effects

______________________________ ______________
Licensed prescriber signature Date

______________________________ ______________
Licensed prescriber printed name Phone Number

____
Address

Revised 5 /2010