SOUTHEAST LOCAL SCHOOL DISTRICT
Health Services
(330) 654-5841 (330) 654-4761 **Fax** (330) 654-9110

Parent Release For Administration of Medication at School

We, the undersigned, request medication be given to our child in accordance with the laws of the State of Ohio and Southeast Local School District School Board Policy.

We understand we must supply the school with:

1. Written permission from the physician to dispense medication at school.
2. Written permission from the parents to dispense medication at school
3. Medication in current prescription bottle or unopened over the counter bottle/package
4. A revised physician statement in the event of dosage change, physician change or any other required information change.

We understand students with inhalers for asthma have the right and responsibility to possess and use prescribed inhalers during school hours, programs, activities and sports in which the school is a participant with written permission from the students' physician and parent on file in the nurses' and principals' office.

We further 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 drug.

_____/_____ _____/_____
*Mother signature date *Father Signature date

*Both parents must sign this release if they are living with or have custody of child. If parents are separated and both still retain legal custody, both parents must sign. If children are in foster home and placement is by agency that holds custody, agency must sign.

SOUTHEAST LOCAL SCHOOL DISTRICT
Health Services
(330) 654-5842 ext. 235 (330) 654-4761 Fax (330) 654-9110

Physician Request For The Administration of Medication at School

Date: _____

Name: _____

Address: _____

Grade:_____ Teacher (Homeroom) _____

Medication to be administered (Name, Dose, Time)

_____

_____

Special Instructions for Administration

_____

Adverse reaction to be reported _____

Medication to begin _____

Medication to cease _____

Physician's Signature _____

Physician's Address _____

Physician's Telephone Number _____