

SCHOOL MEDICATION PERMIT

(In accordance with Ohio Revised Code 3313.713)

The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This section to be completed by the parent or guardian.

Name of Student _____ Birthdate _____
Student's Address _____
School District _____ School _____ Grade _____ Home Room _____

I request school personnel administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility for results of such medication.

Parent/Guardian Signature _____ Date _____
Telephone during school hours _____ Other telephone _____

This section to be completed by the physician.

Medication _____ Date of authorization _____
Dosage _____
Time(s) to be given _____
Date to begin _____ Date to end _____
Adverse reactions to be reported _____
Side effects _____
Student to self administer: Yes _____ No _____
Physician emergency telephone _____ Alternative telephone _____
Special Instructions: _____
Administration _____
Storage _____
Other _____

Prescribing physician (print) _____ Signature _____
Physician's Address _____

For school use only

The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____

12/05, 11/06, 10/4/07, 7/08