

**NORTH ROYALTON CITY SCHOOLS
ADMINISTRATION OF MEDICATION REQUEST**

This form must be completed in its entirety prior to school personnel being permitted to administer medication. The administration of prescription drugs requires a physician's and parent or guardian's permission. The administration of nonprescription drugs requires the parent or guardian's permission. A separate form is needed for each medication. All nonprescription medication indications/instructions must match those that are on the label.

Name of Student: _____ Age: _____ Grade: _____ School: _____

Student Address: _____

Name of Parent (Print): _____ Home Phone: _____ Other Phone: _____

Must be Completed by Parent for ALL Medications:

I request and give consent to any employee of the School Board who has been duly authorized by the Board to administer the medication listed below to my child. I, also, agree to comply with the Ohio law which requires me to deliver (highly preferred), or send the medication to the school in its original container and to comply with the guidelines of School Board Policy. I, also, agree to submit to the school a revised statement signed by the physician if any information contained in the PHYSICIAN REQUEST changes. I, also, understand that it is not the responsibility of school personnel to remind my child to take the medication at the appropriate time.

Parent/Guardian Signature: _____ Date: _____

Reason/Diagnosis for which medication is given: _____

Name of Medication: _____ Dose: _____

Form of Medication: Tablet/Capsule Liquid Inhaler Nebulizer Other: _____

If medication is to be given DAILY, at what time(s): _____

If medication is to be given WHEN NEEDED, describe indications/symptoms: _____

How soon can it be repeated (FREQUENCY): _____

Possible side effects: _____

Special storage requirements: None Refrigerate Other: _____

Other special instructions: _____

Start Date: _____ End Date: _____

Must be Completed by Physician for ALL Prescription Medications:

May the student carry and self-administer this (emergency only) medication? No Yes, (if yes, **MUST** complete back of form)

Physician Name (Print): _____

Physician Address: _____

Physician Phone: _____ Emergency Phone: _____

Physician Signature: _____ Date: _____

This medication request form has been properly completed by the physician and the parent/guardian as required, and the school will administer the medication as outlined.

Principal's Signature: _____ Date: _____

**MUST COMPLETE THIS SIDE FOR SELF-ADMINISTRATION
OF EMERGENCY MEDICATION REQUEST**

The additional information requested below must be completed by both the physician who prescribed the medication, and the parent/guardian of the student. This form must then be delivered to the building principal and school nurse prior to the student's self-medication or possession of a medication. Note: Student Self-Medication is reserved for those students needing emergency medication, such as an inhaler for asthma or an epi-pen for anaphylactic allergic reactions.

Must be Completed by Physician for Student to Self-Administer Medication:

Adverse reactions that should be reported to the physician: _____

Adverse reactions for unauthorized user: _____

Procedure to follow in the event that medication does not produce the expected relief:

Other special instructions: _____

ADDITIONAL INFORMATION FOR ASTHMATIC STUDENTS:

Please circle student's known asthma triggers: Pollens Stress/Anxiety Cold Air Exercise Other: _____

STEPS TO TAKE DURING AN ASTHMA EPISODE DURING SCHOOL:

- Student to request an ESCORT to clinic/office/locker to obtain medication and administer as the doctor ordered.
- Student may return to classroom when _____
- Contact Parent if _____
- Call 6-911 if _____

This patient has been instructed in the proper use of this medication, the expected results, and possible side effects. It is my professional opinion that he/she is capable of and should be allowed to carry and self-administer this medication.

Physician Name (print): _____

Physician Address: _____

Physician Phone: _____ Emergency Phone: _____

Physician Signature: _____ Date: _____

Must be Completed by Parent/Guardian for Student to Self-Administer Medication:

I authorize my child to self-administer the medication described on this form as directed by my child's physician. I also agree to comply with Board policy and regulations regarding self-administration of medication. I also agree to submit to the building principal and nurse assigned to my child's school building a revised authorization, if any of the information contained in the Physician's Authorization or my authorization changes. I, also, understand that pursuant to Ohio Revised Code, Section 3316.716, the Board and its employees are not liable for my child's self-administration of this medication. I, also, understand that it is my responsibility to review with my child when he/she should come to the office or clinic for additional medical assistance.

Parent/Guardian Name (print): _____

Parent/Guardian Address: _____

Parent/Guardian Phone: _____ Alternate Phone: _____

Parent/Guardian Signature: _____ Date: _____