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_____ **DOB** _____
Student's Address_____
School District_____ **School**_____ **Teacher/ Grade**_____

I request school personnel to administer the medication as instructed and agree to (1) deliver the medication to the school, by a parent, in the original container in which it was dispensed 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**_____

_____ **Prescription Medication (physician's signature required)** _____ **Non-Prescription Medication**

Medication _____ **Date of authorization**_____
Dosage _____
Time(s) to be given_____
Date to begin_____ **Date to end**_____
Adverse reactions to be reported_____
_____
_____
_____
Physician emergency telephone_____ **Alternate 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**_____