

MEDICATION FORMS



Please check appropriate school:

- Early Childhood Center  Falls-Lenox Primary  
 Intermediate  Middle School  High School

PLEASE NOTE:

- **THE ADMINISTRATION OF NON-PRESCRIPTION MEDICATION REQUIRES ONLY A PARENT AUTHORIZATION AND REQUEST. NOTE: ALL NON-PRESCRIPTION MEDICATIONS MUST BE ADMINISTERED ACCORDING TO PACKAGE DOSAGE/DIRECTIONS UNLESS OTHERWISE ORDERED BY A PHYSICIAN**
- **THE ADMINISTRATION OF ANY PRESCRIPTION DRUG REQUIRES 1) PARENT AUTHORIZATION AND REQUEST & 2) PRESCRIBER'S STATEMENT**

**I. MEDICATION RESTRICTIONS/CONDITIONS**

1. Generally, it will be the student's responsibility to remember to come to the office for his/her medication. If it is not the specified time as stated within, the staff member responsible for administering the medication will make reasonable efforts to locate the student and administer the medication, or alternatively provide the parent with notification of the missed dosage.
2. **All** medications (**excluding** inhalers and epinephrine auto-injectors that a student has been authorized to carry) will be locked in the clinic or a secure location.
3. Medication forms are valid for the current school year only. Unused medication will be discarded ten (10) days after the last day of school, unless claimed by a parent.
4. **Prescribed** medication must be delivered by a parent or responsible adult in the container provided by the pharmacy.

**II. PARENT AUTHORIZATION AND REQUEST FOR ADMINISTRATION AND/OR USE OF MEDICATION**

DATE \_\_\_\_\_ GRADE \_\_\_\_\_

STUDENT NAME \_\_\_\_\_  
(Please Print)

TYPE OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_ TIME \_\_\_\_\_

FROM \_\_\_\_\_ TO \_\_\_\_\_  
(Date) (Date)

COMMENTS OR CONCERNS \_\_\_\_\_

My child is authorized to carry an inhaler  Yes  No

My child is authorized to carry an epinephrine auto injector  Yes  No

I hereby request that my child, \_\_\_\_\_ be given the above named medication as prescribed by Dr. \_\_\_\_\_. I will provide any and all medication in the **original container** dispensed by the pharmacy. Also, I will notify the school immediately if there is any change in the use of the prescribed medication and if the prescribed medication is to be administered by District staff, I will ensure that the District receives a revised Prescriber's Statement.

It is understood that the Board of Education of the Olmsted Falls School District, its officials, agents, and employees shall be held harmless from all liability for damages or injury, foreseeable or unforeseeable resulting from the administration of such medication.

**BY SIGNING THIS AUTHORIZATION AND REQUEST, I UNDERSTAND AND AGREE TO ABIDE BY THE "USE OF MEDICATIONS" ADMINISTRATIVE GUIDELINES FOR USE IN OLMSTED FALLS SCHOOLS.**

\_\_\_\_\_  
Printed Name of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Phone No.

### III. PRESCRIBER'S STATEMENT

I have prescribed the following to be administered to \_\_\_\_\_,  
(name of student)  
a student at \_\_\_\_\_ (name of school/class): \_\_\_\_\_.  
(name of medication)

Check only one:

I have determined that my child is capable of possessing and using this medication. My child may self-administer this medication, which is required in the event of an emergency; OR

Medication may be administered by designated school staff in accordance with the following (Prescriber to fill out rest of form below only if this box checked):

**Note: Only epinephrine auto-injectors and asthma inhalers may be carried and self-administered by students.**

Dosage to be administered: \_\_\_\_\_

Date administration is to start: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date administration is to cease: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Procedure required for administration, including times or intervals at which each dosage is to be administered: \_\_\_\_\_

Any special instructions, including storage or sterility requirements: \_\_\_\_\_

Severe reactions that should be reported to the Prescriber: \_\_\_\_\_

Severe reactions that may occur to another child for whom the medication is not prescribed, should another child receive a dose of the medication: \_\_\_\_\_

If the medication is an inhaler or epinephrine auto-injector, procedures that should be followed in the event the medication does not produce the expected relief from the student's asthma attack or anaphylaxis: \_\_\_\_\_

Prescriber's printed name: \_\_\_\_\_

Prescriber's Telephone number: \_\_\_\_\_

Prescriber's Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**(Submission of this form by FAX is permissible)**

Rev. 8/01

Rev. 10/12/09

Board of Education Policy #5330

Board of Education Guideline #5330