



MEDICATION FORM

Please check appropriate school:

- Falls-Lenox Primary Fitch Intermediate
 Middle School High School

DATE _____ GRADE _____

STUDENT NAME _____
(Please Print)

TYPE OF MEDICATION _____

DOSAGE _____ TIME _____

FROM _____ TO _____
(Date) (Date)

COMMENTS OR CONCERNS _____

(May carry an inhaler Yes No)

I hereby request that my child, _____ be given the above named medication ** as prescribed by Dr. _____. It is understood that the Olmsted Falls School District and any of its school personnel are absolved from any responsibility which might be associated with the administration of such medication. I will provide any and all medication in its original container which the pharmacy has supplied it in.

Physician's Signature Phone Parent Signature Daytime Phone
(Submission of this form by FAX is permissible)

- ** ANY NON-PRESCRIPTION DRUG REQUIRES ONLY A PARENT SIGNATURE**
**** ANY PRESCRIPTION DRUG REQUIRES BOTH PARENT & DOCTOR SIGNATURE**

MEDICATION RESTRICTIONS/CONDITIONS

1. 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 above, the medication will not be administered without parental notification first.
2. **ALL** medications (**excluding** inhalers) will be locked in the office.
3. Medication forms valid for current school year only. Unused medication will be discarded 10 days after the last day of school unless claimed by a parent.
4. **Prescribed** medication must be delivered by parent or responsible adult.

**BY SIGNING THIS RELEASE, I UNDERSTAND AND AGREE TO ABIDE BY THE
MEDICATION GUIDELINES FOR USE IN OLMSTED FALLS SCHOOLS.**