MEDICATION FORMS

Please check appropriate school:

☐ Early Childhood Center ☐ Falls-Lenox Primary

☐ Intermediate ☐ Middle School ☐ High School

NON PRESCRITION OR OTC MEDICATION

The administration of NON prescription medication/over the counter medication requires only a parent authorization and request. All non prescription medications must be administered according to the package instructions for directions and dosage, other wise it will require a physician's signature. **Please Use Form A**

PRESCRIPTION MEDICATION

The administration of any prescription medication requires both Parent **and Physician Authorization. Please Use Form B**

USE OF MEDICATION GUIDELINES

1. **All medication** must be delivered by a parent or responsible adult in the container provided by the pharmacy.

2. **All** medications that a student needs will be locked in the clinic or in a secure location, except for asthma inhalers and epi-pens

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. All forms may be faxed or hand delivered by a responsible parent

5. Medications for chronic conditions are included in the Health Care Plan. For example: Inhalers and epi- pen authorizations are included in the asthma / allergy Health Care Plans

6. Generally, it will be the Health Care Team's responsibility to give the child his/her medication. If it is not the specified time as stated within, the Team 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.

FORM A **Request for Administration of *Non Prescription* /over the counter Medication**

DATE _____ GRADE _____

STUDENT'S NAME _____
(Please Print)

TYPE OF MEDICATION _____

DOSAGE/Mg _____ TIME _____

FROM _____ TO _____
(Date) (Date)

Reasons for Medication_____

Comments or Concerns_____

I hereby request that my child, _____be given the above medication. This medication will be given **according to package instructions**. Requests for dosages above those indicated on the package require physician authorization.

It is understood that the Board of Education of the Olmsted Falls School District, its officials, agents, and contracted employees (PSI Affiliates and employees) or any of its school personnel shall be held harmless from all liability for damages or injury, resulting from the administration of such medication.

BY SIGNING THIS AUTHORIZATION, I UNDERSTAND AND AGREE TO ABIDE BY THE OLMSTED FALLS "USE OF MEDICATIONS" ADMINISTRATIVE GUIDELINES (Described on Previous page)

_____ _____
Printed Name of Parent Date

_____ _____
Signature of Parent Phone No.

FORM B Request for Administration for Prescription Medication

DATE _____ GRADE _____

STUDENT'S NAME _____
(Please Print)

TYPE OF MEDICATION _____

DOSAGE/Mg _____ TIME _____

FROM _____ TO _____
(Date) (Date)

Reasons for Medication_____

Comments or Concerns_____

I hereby request that my child, _____be given the above

Medication as Prescribed by Dr. _____

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 Physician_____

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: _____

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BY SIGNING THIS AUTHORIZATION, I UNDERSTAND AND AGREE TO ABIDE BY THE OLMSTED FALLS "USE OF MEDICATIONS" ADMINISTRATIVE GUIDELINES (described on previous page)

Parent's printed name_____Phone_____

Parent's Signature_____Date_____

Physician's printed name: _____Phone_____

Physician's Address: _____

Physician's Signature**:** _____ Date**:** _____