ST. MICHAEL SCHOOL

AUTHORIZATION FOR DISPENSING PRESCRIPTION MEDICATION

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 receives medication during the school day.

Student's Name: _____ D.O.B.: ___ / ___ / _____

School Year[1]: 20___ - 20___ Grade: _____ Homeroom: _____

Parent's Name: _____ Primary Phone: (_____) _____ - _____

To be completed by parent/guardian:

I request school personnel to administer the medication as instructed and agree to 1) deliver the medication to the school in the original container (which shows the name of the medicine, child's name, and clear instructions on amount to give, route to give, and how often to give); 2) notify the school if I change physicians, or if the medication is changed or eliminated; 3) NO medication is to be put in the possession of a student. All medications must be brought to the nurse through the main office; 4) cough drops are permitted if a parental permission slip is provided.

The undersigned agree not to file or make any claim against anyone for negligence in connection with the administration or non administration of any medications and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medications. I give my permission for the principal or her/his designee to administer the prescribed medication.

Parent Signature: _____ Date: ___ / ___ / _____

To be completed by child's physician:

Condition for which medical is administered: _____

Name of Medication[2]: _____

Concentration of Medication: _____ (mg/tablet or mg/mil)

Amount of Medication to be given (in milligrams or units): _____

How Administered: _____

Time or Indication for Administration: _____

Possible Side Effects: _____

List any special storage conditions: _____

Date to Start Medication: ___ / ___ / _____

Date to Stop Medication: ___ / ___ / _____

Physician: _____ Physician's Phone: (_____) _____ - _____

Physician's Signature: _____ Date: ___ / ___ / _____

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[1] This permission is no longer valid at the end of the current school year.
[2] A separate form is required for each medication to be given.