Authorization for the Administration of Medication by School Personnel

As required by Section 3313.713 Ohio Revised Code

STUDENT NAME _____ DATE OF BIRTH _____

SCHOOL_____ GRADE_____ TEACHER _____

Parent/Guardian Section

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. This form must be completed by both the parent (top section) and the licensed prescriber (bottom section).
2. Medication must be kept in the student's labeled prescription bottle (Pharmacy may provide an extra bottle for long-term medication). Prescription label must match instructions from prescriber. If it is a non-prescription medication, it must be in the original container.
3. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.)

When possible, give medication outside of school hours. For example, to be able to administer three (3) doses to the child, it might be given before school, immediately after school, and before bedtime. Please contact the school nurse if you have questions.

Signature of parent: _____ Date: _____

Licensed Prescriber Section

I verify that this medication must be taken by: _____
Name of Student

Diagnosis for which medication is prescribed: _____

Medication _____ Strength _____ Dose _____

Time medication is to be taken: _____ Administration start date: _____ Expiration Date:_____

Instructions or precautions, including possible side effects: _____

Licensed prescriber signature: _____ Date:_____

Licensed prescriber printed name: _____ Phone:_____

Teacher _____
Room # _____

_____ **Prescriber order on file**
_____ **Parent signature on file**

MEDICATION LOG

Student _____ School _____ Date Started _____ School Year _____

Medication _____ Dose _____ Time _____

Medication _____ Dose _____ Time _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUG																															
SEP																															
OCT																															
NOV																															
DEC																															
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUN																															

Secretary: _____ Principal: _____ Nurse: _____

Other Designee: _____ Other Designee: _____ Other Designee: _____

KEY
Initials= Med Take within 1 hour of designated time
O = No medication available
ab= Absent
x=No School
ns = No Show
er= Error

COMMENTS and SPECIAL INSTRUCTIONS

Picture of Student