Prescription - Medication Permit

(In accordance with Ohio Revised Code 3314.713)

Please use a different form for **EACH** medication.

This section to be completed by the **parent or guardian.**

Name of Student: _____ Birth date: _____

Student Address: _____

School Building: _____ Grade: _____

I request the designated / trained medical person to administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I agree to hold the appointed school personnel and the Board of Education free from all responsibility for ill results of such medication.

FOR INHALERS, EPI-PENS, INSULIN PUMPS: I authorize my student to possess and use the below listed medication, as prescribed at the school and any activity, event, or program sponsored by the school. I will provide the designated person with back up medication of additional Epi-pen and Insulin as required by law.

I understand that an emergency medical service provider (911) will be called if Epi-pen is administered.

Parent/Guardian Signature: _____ **Date**: _____

Printed Name: _____ **Phone #'s** _____ _____

This section to be completed by the **physician.**

Medication: _____ **School Year date**: 20 _ to 20___

Dosage: _____ **Route:** _____

Time(s) to be given: _____

Reason / Purpose of medication: _____

Special Instructions: _____

_____

Adverse reactions to be reported: _____

FOR INHALERS, EPI-PENS, INSULIN PUMPS: As the prescriber, I have determined that this student is capable of possessing and using the medication appropriately and has been provided with training in the proper use of the above medication

Prescribing Physician Signature:_____ **Date**: _____

Print Physician Name : _____**Physician Phone number:** _____

THIS FORM WILL BE KEPT ON FILE AND EXPIRES AT THE END OF THE SCHOOL YEAR.