



# MEDICATION PERMISSION FORM

Complete and return this form to your school to provide parental authorization and physician's request for the administration of prescription and non-prescription drugs, herbs, supplements, and medication to a student by school personnel. A new, separate form should be submitted for each individual medication.

District policy requires consent of the parent/legal guardian and a written statement from the doctor/dentist accompanied by written permission from a parent before medication can be given to a student by school personnel. This includes over-the-counter medication. Medication must come to school in the original container with the affixed label from the pharmacist. Prescription medication must show the date, student's name, name of medication, dosage directions, licensed prescriber's name, and rx number (if there is one). A written order from the physician is required for a student to carry an inhaler or Epi-Pen. The following information is necessary in order to comply with this policy. See Board of Education policy 5330 for more information.

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Home Room \_\_\_\_\_ Teacher (elementary only) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### TO BE COMPLETED BY PHYSICIAN / DENTIST (one form per medication):

Medication	Dosage	Time	Beginning Date	End Date
_____	_____	_____	_____	_____

Adverse Reactions (Notify Physician) \_\_\_\_\_

Instructions for Administration, Storage and Sterile Conditions \_\_\_\_\_

Physician/Dentist Name \_\_\_\_\_

Physician/Dentist Address \_\_\_\_\_ Physician/Dentist Fax \_\_\_\_\_

Physician/Dentist Phone \_\_\_\_\_ Physician/Dentist Emergency Phone \_\_\_\_\_

Physician/Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

### TO BE COMPLETED BY PARENTS / GUARDIANS:

I/we understand and give my permission for a Forest Hills School District designated employee to administer the medication as prescribed above to my child. In addition, I/we understand:

- An adult must bring the medication to school in the original container and medication cannot be administered until this form is completed and on file in the school health office.
- I will notify the school if the medication or dosage is changed or discontinued by prescribing physician/dentist completing a revised form.
- I authorize and request Forest Hills School District and any of its designated employees to administer the above drug or medication to my/our son/daughter. I agree to discharge the Forest Hills School District, the Forest Hills School District Board of Education, Board members individually and employee(s) of the district who administer prescribed medication from any and all liability, actions, claims and demands –of any kind—that I/we may have on behalf of myself/ourselves and my/our named child regarding any and all injuries, losses and damages /our named child may sustain from the administration of the prescribed medication or any injury or damages that may result from my/our child's failure to take the prescribed medication as administered by and employee of the school district.
- If an authorization to carry Epi-Pen is indicated by a physician, I will provide a back up dose of Epi-Pen. (Ohio Revised Code 3313.718) Emergency medical services will be called if Epi-Pen is administered.
- If student carries an inhaler, an authorization to carry must be noted in the above instructions.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

### TO BE COMPLETED BY SCHOOL

RECEIVED BY \_\_\_\_\_ DATE \_\_\_\_\_