6-12 ADMINISTRATION OF MEDICATION

SYLVANIA SCHOOLS

4747 N. Holland-Sylvania Rd.
Sylvania, Ohio 43560

Valid for School Year: _____

Self-administered prescription medication to students in grades 6 through 12 shall remain the sole responsibility of the parent/guardian. (The only exception would be students covered by the requirements of IDEA or ADA). However, it is important for the school to know who is self-administering medications, the type, dosage of medication, and the possible side effects.

Student's Name:_____ D.O.B.:_____ School:_____
Parent's Name:_____ Phone:_____
Address:_____
Name of Medication_____ Purpose_____
Dosage_____ Frequency_____ Method_____
Anticipated reaction(s) to medication_____
Special storage instructions_____

1. I am requesting permission for my child named above to self-administer prescription medication for the purpose stated.
2. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
3. **HB 121 Provides schools/school employees with protection from liability resulting from the use/misuse of inhalers by students.**

_____ _____
Date Parent/Guardian Name

_____ _____
Phone Address

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HB 121 Requires Physicians to provide information which includes the name of the drug, possible side effects/reactions and a phone number to contact the Physician in the event of an emergency.

TO BE COMPLETED BY THE PHYSICIAN

_____ _____
Physician's Name (please print) Address

_____ _____
Physician Signature Phone Date

***Please return to your child's school after completion