K-12 ADMINISTRATION OF MEDICATION

SYLVANIA SCHOOLS

4747 N. Holland-Sylvania Rd
Sylvania, Ohio 43560

Valid for School Year: _____

A completed form must be on file for any student requiring medication during school hours.
Student's Name:_____ D.O.B.:_____ School:_____
Parent's Name:_____ Phone:_____
Address: _____

The parent signing below:

1. Requests and gives permission to the principal or designee to administer the medication described below to their child.
2. Will deliver this medication to the school. **NOTE: Medication is NOT to be brought to school by the student.**
3. Will notify the school if the medication, dosage, or procedure is changed or if it is to be eliminated, and provide a physician order reflecting the change.
4. All medication dispensed at school **must** have a prescription label with medication, dosage, and times taken.
5. Asthma inhaler, Auvi-Qs and EpiPens may be self-administered with a physician order; all other medication will be under the control and supervision of school personnel.
6. Over the counter medications will require a physician signature and must also be under control and supervision of school personnel

HB 121 Provides schools/school employees with protection from liability resulting from the use/misuse of inhalers by students.

Parent/Guardian Signature_____ Date _____

To be completed by the student's Primary/Managing Physician

Name of medication_____ Purpose of medication_____
Duration of medical treatment_____
Dosage_____ Frequency_____ Method of administration_____
Anticipated reaction(s) of student to medication_____
Reactions which should be reported to physician_____
Special instructions (storage/sterile requirements)_____
Date_____ Physician's Signature_____
Physician's Name_____ Address_____
Please return to student's school after completion either via parent, mail, or fax.