Request for Administration of Prescription Medication by School Personnel

(not to be used for Epinephrine or Inhalers)

Student's name: _____ **Birthdate:** _____ **School/Grade/Teacher:** _____

- The student's Ohio licensed health care prescriber must complete and sign Section I of this form each school year.
- Parent/guardian must complete and sign Section II of this form each school year.
- This completed form must be on file in the student's health record before prescription medication will be administered by school personnel. A separate form is required for each individual medication.
- Medication must be in the original container as dispensed by the physician, pharmacist, or manufacturer and will be stored in the school clinic.

I. Prescriber's Section

Prescriber's name/title (printed): _____ Phone: _____

This is to certify that the student named above is under my care and should receive the following medication at the following times during the school day:

Medication name and strength	
Dose	
Route	
Time (during school or school activity)	
Severe adverse reactions to be reported to prescriber	
Special instructions for administration	
Possible side effects	
Special storage instructions	
Starting & ending date of this request	Start _____ End _____

Prescriber's signature/title: _____ Date: _____

Address: _____ Emergency contact #: _____

II. Parent/Guardian's Section

I hereby request and give my permission for St. Brigid personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued.

I agree to submit a revised Medication Administration form if any changes are made regarding the above medication.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____

Medication Intake / Sign Out

Date	Time	Quantity	Initials		Event Description - list INTAKE or SIGN OUT AND additional details (i.e., field trip, med request, med error, wasted etc)	Date Returned	Time Returned	Quantity Returned	Initials Returned	

Month	AUG		SEPT		OCT		NOV		DEC		JAN		FEB		MAR		APR		MAY		JUN	
Discrepancy	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Initials																						

Disposal Directions:
All meds should be returned to parent/guardian of appropriate student. If multiple attempts were made unsuccessfully, please complete the following procedure.
All non-controlled medications should be disposed of in sharps container in the presence of the building administrator or SRO.
All controlled medications should be disposed of in the community prescription drug drop box located in the lobby of the Dublin Justice Center, 6565 Commerce Parkway.
All controlled medication must be disposed of in the presence of two (2) staff members, one of which must be the SRO or an administrator. Both signatures are required.

Date	Medication	Dose	Qty	Manner of disposal	Signature	Signature