NEW PHILADELPHIA CITY SCHOOLS

New Philadelphia, Ohio 44663

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

(PLEASE PRINT LEGIBLY AND COMPLETE ALL AREAS)

Building ____________________________ STUDENT'S ADDRESS ____

Grade ____________________________ ____

____ is under my care and should receive ______________________________________

(Name of student) (Name of drug, dosage, route)

at the following times: ____.

This medication is being prescribed for treatment of ____.

Specific instructions for administration of medication, including sterile conditions, storage, and if inhaler/Epinephrine auto injector; procedure to follow in the event the medication does not produce the expected relief:

____

____

Significant side effects (adverse reactions) which should be reported to physician: ______________________________________

____

Significant side effects (adverse reactions) that may occur to another student whom the medication is not prescribed :

____

Administration of medication to begin __________________________________ and end ____________________________________

(date) (date)

For auto injector or inhaler medication: as the prescriber I have determined that this student is capable of possessing and using this auto injector or inhaler appropriately and have provided the student with training in the proper use of the auto injector or inhaler.

____ ____

(Physician's Signature) (date)

____ ____

(Physician's Name – print) (phone number)

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

PARENT PERMISSION: I request New Philadelphia City Schools personnel administer the above medication to:

____.

(Student's Name)

Reasonable care will be exercised in the administration of medications. I also give my permission for the school nurse to communicate with the physician regarding this medication. I understand that this is necessary to ensure the safe administration of this medication. A parent/guardian must transport all medication to school personnel.

If applicable: as the Parent/Guardian of this student, you authorize your child to possess and use an asthma inhaler/epinephrine auto injector as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. As the Parent/Guardian, you understand that a school employee will immediately request assistance from an emergency medical service provider if the epinephrine is administered. ***You must provide a backup dose of the epinephrine medication to the school as required by law.***

MEDICATIONS MUST BE SUPPLIED TO SCHOOL IN THE ORIGINAL CONTAINER.

____ ____________________________________

PARENT/GUARDIAN SIGNATURE DATE

Initial in the appropriate box to indicate the medication was given.

DAY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE
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Person(s) authorized to administer medication for student:

Nurse: ____________________________ Signature:___________________________ Initials: _________ Date: __________

Secretary: _________________________ Signature:___________________________ Initials: _________ Date: __________

Teacher: __________________________ Signature:___________________________ Initials: _________ Date: __________

Other: ___________________________ Signature: __________________________ Initials: _________ Date: __________

KEY:

0 = MEDICATION NOT AVAILABLE **X = NO SCHOOL** **AB = ABSENT**