BISHOP LEIBOLD SCHOOL

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

****This form must be completed by the physician even for over-the-counter medications.****

As required by Section 3313.713 Ohio Revised Code

_____ _____

Name of Student Date of Birth

_____ _____ _____

Address School Grade/Teacher

PARENT/GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child then sign this section:

1. Both the parent and the licensed prescriber must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication). The prescription label must match the instructions for the prescriber.
3. If it is a non-prescription medication, it must be in the original container.
4. **ALL MEDICATIONS MUST BE BROUGHT TO SCHOOL BY PARENT/GUARDIAN, NOT BY THE STUDENT**.
5. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.).
6. School personnel are authorized to administer only oral medications, eye drops, inhalers, insulin, and some medications used in emergency situations (such as use of an Epi-pen).

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

IMPORTANT:

The medication for the student listed below cannot be scheduled for other than school hours. I am fully aware that such requested medication may be, by necessity, administered under the supervision of medically unlicensed personnel (OAC 4723-13-02) when the school nurse is not present. With this in mind, I request that the medication as indicated on the other side, be administered by school personnel who have been trained by the school nurse to administer oral medications, eye drops, inhalers, insulin, and some medications necessary for in emergency situations (such as an Epi-pen.) As the parent/guardian of this student, I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medications. I request that this medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

_____ _____

Signature of Parent/Guardian Date

LICENSED PRESCRIBER SECTION

PHYSICIAN PERMISSION FOR ADMINISTRATION OF MEDICATION TO STUDENTS

The following student is under my care and should receive the medication indicated below. Since it is not possible to arrange for this medication to be taken at home under parent supervision, it is requested that it be administered at school.

I verify that this medication must be taken by: _____
Name of Student

Diagnosis for which this medication is prescribed_____

_____
Name of prescribed medication

_____ _____
Dosage Route

_____ _____
Time medication is to be administered Administration start date

Severe adverse reactions that should be reported to the physician _____

_____

_____

Special Instructions or precautions for administration of medication:: _____

_____

_____

_____ _____
Licensed prescriber signature Date

_____ _____
Licensed prescriber printed name Telephone Number

****ONE MEDICATION PER FORM

*****ANY REVISION TO PHYSICIAN'S PRESCRIPTION REQUIRES A NEW FORM

2020-21