SCHOOL MEDICATION PERMIT

(In accordance with Ohio Revised Code 3313.713)
The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This section to be completed by the parent or guardian.

Name of Student ____ Birthdate ________________________
Student's Address ____
School District ________________________ School _________________ Grade ____ Home Room ___________

I request school personnel administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility for results of such medication.

Parent/Guardian Signature ____ Date ______________________
Telephone during school hours ____________________________ Other telephone _______________________

This section to be completed by the physician.

Medication ____Date of authorization ________________
Dosage ____
Time(s) to be given ____
Date to begin ___________________________________ Date to end _____________________________________
Adverse reactions to be reported ____
Side effects ____
Student to self administer: __________ Yes __________ No ____
Physician emergency telephone ___________________________ Alternative telephone __________________
Special Instructions:
Administration ____
Storage ____
Other ____

Prescribing physician (print) _______________________________ Signature _____________________________
Physician's Address ____

For school use only

The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature ____ Date _______________________________
Signature ____ Date _______________________________
Signature ____ Date _______________________________

12/05, 11/06, 10/4/07, 7/08

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