Mount Vernon City School District

Request for Administration of Prescription and Nonprescription Medication by School Personnel

(not to be used for Epinephrine or self-carry Inhalers)

Student Information:

Student Name:_______________________________ Birthdate:________________ School Year: _________________

Address: ____________________________________ City: ___________________ School: _______________________

Grade level: _____________ Height: _________ Weight: __________ Teacher: ________________________________

Any Known Drug Allergies/Reactions: ____

This form **must** be completed by an Ohio licensed health care prescriber each school year. I authorize the exchange of information between the healthcare provider and the school regarding this medication when deemed necessary. This completed form must be on file before any medication can be administered by school personnel. A separate form is required for each medication and a **new** form is required if any changes are made regarding this medication.

Medication Information:

Medication: __________________________________ Circumstance for use: __________________________________

Dosage: _________________ Route: ________________ Time medication is to be given: ______________________

Start Date: ______________ End Date: ______________ Is this medication a controlled substance ☐Yes ☐No

Special Instructions for administration:____

Possible adverse reactions which should be reported to the parent/physician:

____

Possible adverse reactions to student for whom it is not prescribed to receives a dose:

____

Prescription medications must be in original container with pharmacy label

Required Signature:

Physician Signature: ______________________________ Physician Name: __________________________________

Physician Address: __________________________ Physician Phone & Fax #: _______________________________

I hereby request and give my permission for school district 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 office or clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued. If medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities.

Required Signature:

Parent/Guardian Signature: ______________________ Parent/Guardian Printed Name:______________________

Date: ______________ Address: __________________________________ Daytime phone: ____________________