"We Inspire and Empower Learners"

NSG-300A
Rev. 02-2012

NORTH ROYALTON CITY SCHOOLS
ADMINISTRATION OF MEDICATION REQUEST

This form must be completed in its entirety prior to school personnel being permitted to administer medication. The administration of prescription drugs requires a physician's and parent or guardian's permission. The administration of non-prescription drugs requires the parent or guardian's permission. A separate form is needed for each medication. All nonprescription medication indications/instructions must match those that are on the label.

Name of Student:___________________________Age:_______Grade:_______School:______________________________________

Student Address:____

Name of Parent(Print):_________________________Home Phone:_____________Other Phone:________________________________

Must be Completed by Parent/Guardian for *ALL* Medications:

I request and give consent to any employee of the School who has been duly authorized by the School Board to administer the medication listed below to my child. I will comply with the Ohio law which requires me to deliver the medication to the school in its *original container* and to comply with the guidelines of School Board Policy. I also agree to submit to the school a revised statement signed by the physician if any information changes or the medication is cancelled. I understand that it is not the responsibility of school personnel to remind my child to take the medication. I further agree to hold harmless the Board of Education, all school employees, and agents from any and all liability for damages or injury resulting directly or indirectly from the administration of the medication to my child.

Parent/Guardian Signature:____Date:______________________

Reason/Diagnosis for which medication is given:____

Name of Medication: ____ Dose:____

Form of Medication (please check): ____Tablet/Capsule ____Liquid ____ Inhaler ____ Nebulizer ____Other: ______________

If medication is to be given **EVERYDAY/DAILY**, at what time(s):____

If medication is to be given **ONLY WHEN NEEDED**, describe indications/symptoms: _____________________________________

____

How soon can it be repeated if necessary (**FREQUENCY**): ____

Possible Side Effects: ____

Special Storage Requirements: ____None ____ Refrigeration ____ Other: ____

Other Special Instructions: ____

Start Date: ____________________ End Date: ________________________

Must be Complete by Physician for *ALL* Prescription Medications:

Physician Name (Print): ____

Physician Address: ____

Physician Phone: ___________________________________ Emergency Phone: ____

Physician Signature: ____ Date: _____________________________

May the student carry and self-administer this "Emergency-Only" Medication? ____No ____Yes (if yes, **MUST** Complete back of form)

This medication request form has been properly completed by the physician and the parent/guardian as required, and the school will administer the medication as outlined

Principal's Signature: ____Date:____________________________________

MUST COMPLETE THIS SIDE FOR *SELF-ADMINISTRATION* OF *EMERGENCY MEDICATION* REQUEST

*The **additional** information requested below must be completed by **both** the **physician** who prescribes the medication, and the **parent/guardian** of the student. This form must then be delivered to the building principal and/or school nurse **prior** to the student having possession of the medication.* ***Note: Student Self-Medication is reserved for those students needing EMERGENCY MEDICATION, such as an inhaler for Asthma or an EpiPen for Anaphylactic Allergic Reactions.***

Must be Completed by Physician for Student to Self-Administer Medication:

Adverse reactions that should be reported to the physician: ____________________

Adverse reactions for **UN**authorized user: ____________________

Procedure to follow in the event that medication does not produce the expected relief: ____________________

____

Other Special Instructions: ____________________

____

ADDITIONAL INFORMATION FOR ASTHMATIC STUDENTS

Please circle student's known Asthma triggers: Pollens Stress/Anxiety Cold Air Exercise Other: ____________

STEPS TO TAKE DURING AN ASTHMA EPISODE DURING SCHOOL:

*Student to request an ESCORT to clinic/office/locker to obtain medication and administer per doctor's order

*Student may return to classroom when: ____________________

*Contact Parent IF: ____________________

*Call 911 IF: ____________________

This patient has been instructed in the proper use of this medication, the expected results, and possible side effects. It is in my professional opinion that he/she is capable of and should be allowed to carry and self-administer this medication:

Physician Name (print): ____________________

Physician Address: ____________________

Physician Phone: ____________________ Emergency Phone: ____________________

Physician Signature: ____________________ Date: ____________________

Must be Completed by Parent/Guardian for Student to Self-Administer Medication:

I authorize my child to self-administer the medication described on this form as directed by my child's physician. I also agree to comply with Board policy and regulations regarding self-administration of medication. I, also, agree to submit to the building principal/nurse assigned to my child's school building a revised authorization, if any of the information contained in the Physician's Authorization or my authorization changes. I, also, understand that pursuant of Ohio Revised Code, Section 3316.716, the Board and its employees are not liable for my child's self-administration of this medication. I, also, understand that it is my responsibility to review with my child when he/she should come to the office or clinic for additional medical assistance. I understand that if my child is authorized to carry an EpiPen, a backup dose will be kept on file in the clinic per Ohio law.

Parent/Guardian Name (print): ____________________

Parent/Guardian Address: ____________________

Parent/Guardian Phone: ____________________ Alternate Phone: ____________________

Parent/Guardian Signature: ____________________ Date: ____________________