



ADMINISTRATION OF MEDICATION TO STUDENTS DURING SCHOOL HOURS

All medication should be given at home when possible. The administration of prescribed medication and/or medically-prescribed treatments to a student during school hours will be permitted only when failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or if the child is disabled and requires medication to benefit from his/her educational program. In the event that it is necessary for a student to receive medication during the school day, the following requirements must be met prior to the administration of medication:

- ✓ **PRESCRIPTION MEDICATION:** An Administration of Medication Request form must be completed and signed by both the physician and parent/guardian.
- ✓ **OVER-THE-COUNTER MEDICATION (Nonprescription):** An Administration of Medication Request form must be completed and signed by the parent/guardian.
- ✓ The first dose of any new medication will not be administered at school in case of an allergic reaction.
- ✓ It is the student's responsibility (age appropriate) to report to the clinic at the designated time to receive the medication ordered.
- ✓ All medication **MUST** be brought to school by the parent/guardian. Students are not permitted to carry or transport medication unless previously authorized by the school, physician, and parent/guardian and is an Emergency medication (i.e., Inhaler, Epi).
- ✓ All Prescription medication must be labeled appropriately by the pharmacist or physician and in its original container. The label must state the student's name, dosage, and time(s) to be taken and must match the Administration of Medication Request form.
- ✓ All Nonprescription medication must also be in its original container and labeled with a permanent marker indicating the child's name. Medication not in its original container will not be administered to the student.
- ✓ The recommended dosage on the box of the nonprescription medication will be reviewed and compared to the parent/guardians request. If the dosage exceeds amount recommended on the medicine container/box, it must be requested by a physician's order on an Administration of Medication Request form.
- ✓ The principal or appointed representative will supervise the administration of the medication in the absence of the school nurse.
- ✓ Any change to the medication must be submitted on a new Administration of Medication Request form. If a prescriptive medication is to be discontinued, a written note must be provided by the practitioner.
- ✓ New Request forms must be submitted for each new school year and for each medication.

Parent(s)/Guardian(s) MUST pick up any unused medication. Medication will not be sent home with the child unless previously authorized and is an emergency medication. All medications not retrieved will be disposed of according to Ohio Revised Code.



"We Inspire and Empower Learners"

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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): _____ 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 **ONLY WHEN NEEDED**, describe indications/symptoms: _____

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

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:** _____

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: _____