Parental/Legal Guardian Authorization For Administration of Medication or Treatment at School (Needed for Prescription and Nonprescription Medications)

To the Parent/Legal Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE ANY MEDICATIONS OR MEDICAL TREATMENTS IN SCHOOL. **ALL SPACES MUST BE COMPLETED.**

_____ _____ _____

Printed Student Name Date of Birth Home Address

_____ _____ _____

School Homeroom Class Grade

A. *I am requesting permission for my child named above to : (Check one or both)*
   _____ *use or receive the following medication:*
   *Name of Medication:*_____ *Dosage:* _____
   Time to be Administered: _____ *Dates to be Administered:* _____
   _____ *self-administer the above named medication in the presence of an authorized staff member.*
B. *I understand that the medication must be sent in its original container, in good condition, and with a current expiration date, or it will not be given at school.*
C. *I will assume responsibility for safe delivery of the medication to and from school. I understand that any left-over medication will be disposed of on the last day of school unless picked-up by me.*
D. *I will immediately notify the school of any changes in the use of the medication. If the medication is a prescription medication, I will obtain a new form from the licensed prescriber noting the changes.*
E. *I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly from or indirectly from this authorization.*

_____ _____ _____

Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

Home #_____ Cell #_____ Work#_____

Contact Information for Parent/Legal Guardian

Authorization for Staff

The following staff member(s) are authorized to administer this medication/medical treatment:_____

_____

_____ _____ _____

Printed Name of Principal Signature of Principal Date

Lynchburg-Clay Local School District

www.lynchclay.k12.oh.us

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Licensed Prescriber's Authorization for Administration of Medications/Medical Treatments at School (Needed only for Prescription Medications/Treatments)

To the Prescriber:

Lynchburg-Clay School District requires that all of the following information be provided before it will administer any prescription medication or treatment to any student.

_____ _____

Printed Name of Student Student Date of Birth

I am a licensed health professional in the state of Ohio authorized to prescribe drugs, I have prescribed the following medication with the following instructions to the above named student:

A. *Name of Medication:* _____
B. *Route to be Administered:* _____
C. *Dosage of the medication to be administered:*_____
D. *Scheduled time for medication to be administered:* _____
E. *Date the administration of the drug/treatment is to begin:* _____
F. *Date the administration of the drug/treatment is to end:*_____
G. *Specify any special instructions for administration of /storage of the medication:*_____
_____

F. *Report the following side effects (i.e. sever adverse reactions) to my office immediately:* _____
_____
_____

Please check one:

_____ This medication/treatment should be administered by authorized staff only.

_____ I have educated the student regarding administration of this medication/treatment and authorize the student to self-administer this medication in the presence of an authorized staff member.

_____ _____ _____

Printed Name of Prescriber Signature of Prescriber Date

Office #_____ Fax #_____ Alternative #_____

Contact Information for Prescriber