Appendix A

ORC 3313.713

AUTHORIZATION TO DISPENSE MEDICATION

Student Name_____ Grade_____

Student Address_____ Building_____

Part I: Parental Request

I request that the medication described below be administered to_____
Student Name

and grant permission for an authorized individual from St. Henry Consolidated Local Schools to administer the medication. I have read and understand the Board's policy regarding administration of drugs to students.

_____
Signature of Parent or Guardian Date

Part II: To Be Completed by Physician for Prescribed Drugs

A. Name of drug: _____ Dosage:_____

B. Time/Intervals for administration: ___four hours ___six hours ___eight hours
___before meal ___after meal ___with meal
___other:_____

C. Medication is to begin (began) on _____ and is to end on _____
Date Date

D. Severe reactions which are to be reported to physician and/or parent include:_____

_____

_____

E. Medication storage: ___room temperature ___refrigerate ___other:_____

F. Special instructions:_____

_____

_____
Signature of Prescribing Physician Date

(OVER)

Part III: To Be Completed by Parent for Non-Prescription Drugs

A. Name of drug:_____ Dosage:_____

B. Time interval for administration:____four hours ____six hours ____eight hours
____before meal ____after meal ____with meal
____other (explain)_____

C. Medication is to begin (began) on _____ and is to end on _____.
Date Date

D. Possible reactions: _____

Report reactions to: _____
Name Phone Number

E. Medication storage: ____room temperature ____refrigerate____other:_____

F. Special instructions: _____

_____

G. As parent, guardian, or person responsible for this child, I assume all responsibility for the administration of this medication and release the school from any liability associated with its use which was with my permission and at my request.

_____
Signature of Parent/Guardian Date

_____
Witness to Signature Date

_____

Part IV: To Be Completed by Principal and/or Authorized Person

Received request_____ _____
Date Principal or designated person signature

Complied with request: _____ _____
Date Name of individual dispensing drug signature

Medication completed per request: _____
Date