BIG WALNUT LOCAL SCHOOLS | INSPIRE & GUIDE

MEDICATION ADMINISTRATION FORM

Student Information:

Student Name:_____Birthdate:_____School Year:_____

Address:_____School_____Grade level_____

Height:_____Weight:_____ Any Known Drug Allergies/Reactions:_____

Medication Information:

Medication:_____Cirumstance 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 a student for whom it is not prescribed to receive a dose:

_____

Required Signatures:

Prescription Medication Only:

Physician Signature:_____Physician Name:_____

Physician Address:_____Physician Phone/Fax Number_____

Prescription medications must be in the original container with pharmacy labels. The form is valid for the dates listed or one school calendar year. All medications must be in their original containers and not expired. Medications are not permitted on the bus unless prior authorization is obtained.

(over)

Parent/Guardian Authorization for Prescription Medication:

I authorize an employee of the school board to administer the above-listed medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of the medication is changed. I release and agree to hold the Big Walnut Board of Education, its officials, and its employees harmless from any liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. The medication form must be received by the principal, designee, or school nurse. I understand the medication must be in the original container and properly labeled with the student's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and date of expiration when appropriate.

Parent Signature:_____ Date:_____

Non-prescription (Over the Counter) Medications:

As a parent or legal guardian of the above-named student, my signature authorizes school personnel to administer the non-prescription medication listed above. This medication will be administered according to the package directions unless otherwise directed by a physician (requires physician signature). I understand that a trained staff member administering the medication might not be a healthcare professional. I agree to deliver the medication to the building in the original container. I release and agree to hold the Big Walnut Board of Education, its officials, and its employees harmless from any liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

PARENT'S STATEMENT

I have read the above statements and agree to them.

Parent/Guardian Signature:_____Date:_____

SELF-ADMINISTER OVER-THE-COUNTER (OTC) MEDICATION: Only for students grades 7-12

As the parent/legal guardian of the named child, I am requesting that he/she be allowed to carry and self-administer an OTC medication. My signature below indicates that I have instructed my child on the proper use of this medication. The Board of Education or their designee reserves the right to deny or revoke permission for self-medication at any time. I release any claims against the Board of Education or its employee for allowing the above-named student to self-administer medication(s) in accordance with this request. This form is in effect for the duration of the current school year.

Parent/Guardian:_____Date:_____