BIG WALNUT LOCAL SCHOOLS | INSPIRE & GUIDE

MEDICATION ADMINISTRATION FORM

Student Information:

Student Name:_____Birthdate:_____School Year:_____

Address:_____School_____Grade level_____

Height:_____Weight:_____ Any Know 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 student for whom it is not prescribed to receives a dose:

_____

Prescription medications must be in original container with pharmacy label

Required Signatures:

Prescription Medication Only:

Physician Signature:_____ Physician Name:_____

Physician Address:_____ Physician Phone/Fax Number_____

(over)

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 at trained staff member administering the medication might not be a health professional. I agree to deliver the medication to the building principal or office secretary in the container in which it was dispensed in its original container. I will notify the building principal in writing

if the mediation, dosage, procedure or any information is changed or is to be eliminated. If requested, I will discuss with school officials the effect of the medication or procedure given at school. I release any claims against the Board of Education or its employees arising from the administration of medication in accordance with this request.

PARENT'S STATEMENT

I have read the above statements and agree to them.

Parent/Guardian Signature:_____Date:_____

PRINCIPAL'S STATEMENT

Principal's Signature:_____Date:_____

SELF-ADMINSTER OVER-THE -COUNTER MEDICATION

As the parent/legal guardian of the named child, I am requesting that he/she be allowed to carry and self-administer an over –the-counter medication. My signature below indicates that I have instructed my child on the proper use of this medication. This student is not permitted to possess or carry more than a one day supply of any over-the counter 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:_____