Authorization for the Administration of Medication or Treatment by School Personnel

As required by Section 3313.713 Ohio Revised Code

The Board of Education urges you to schedule, to the extent possible, medication or treatment of a student outside of school hours. When that is not possible, medication and/or treatment will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.
Medication/treatment will only be given at school when this form is completed and signed by the physician/licensed prescriber and the parent/guardian.

PHYSICIAN/LICENSED PRESCRIBER SECTION: ***May fax their authorization to 419-998-2929***

Student Name _____ Address _____

School _____Apollo Career Center_____ Grade _____

The above student should receive_____
Name of Medication/Strength/Dose

at the following times _____
Special instructions or precautions (possible side effects) _____ _____
Starting date for medicine/treatment _____ Ending date _____

_____ _____
Signature of physician/licensed prescriber Date

_____ _____ _____
Printed name of physician/ licensed prescriber Office Phone Number FAX Number

PARENT/GUARDIAN SECTION

I request that medication be administered to my son/daughter according to the directions of the physician/licensed prescriber in the above section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Name of Child _____ Name of Drug_____

1. A parent/guardian will deliver the medication to the school in the original container properly labeled with the name and strength of medication, name of student, name of doctor, and directions for use. (The pharmacy may provide an extra container for long-term medication). For a non-prescription or over-the-counter medication, medicine must be in the original container and only the bottom section of this form needs to be completed by the parent. If you are requesting a different dose than the manufacturer's recommended dose to be given to the student, you must also have a physician's or licensed prescriber's signature on this form.

2. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. New forms must be submitted each school year AND for each new medication or when any changes in the original form occur.

3. I release and agree to hold Apollo Career Center Board of Education and its employees harmless from any dangers or injury resulting directly or indirectly from this authorization.

Signature of parent/guardian _____ Date _____
Telephone number _____ Work telephone number _____