ELIDA LOCAL SCHOOLS

AUTHORIZATION TO ADMINISTER A PRESCRIBED **MEDICATION** OR TREATMENT

The School District, in accordance with ORC 3313.716, requires that all of the following information be provided before it will administer medication or treatment to the student.

Student Name_____ Grade_____ Date_____

Address:_____ Home Phone:_____

Parent* work phone:_____ Parent* cellular or other phone:_____

Parent/Guardian

A. I am requesting permission for my child named above to: (Check all that apply)
   _____ use/receive prescribed medication(s)/treatment(s)
   _____ self-administer prescribed medication(s) in my presence or that of authorized staff

B. I will assume responsibility for safe delivery of the medication/drug to school. (Medication may not be transported with the student via the school bus.) (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)

C. I will submit to the District a revised authorization statement, signed by the prescriber, if any of the information contained in the statement changes.

D. 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 or indirectly from this authorization.

_____ _____
Signature of Parent/Guardian Date

Prescriber
Name, dosage, and time or intervals medication is to be administered:

_____

_____

Date the administration of the drug is to begin_____
Date the administration of the drug is to cease_____

Specify any special instructions for administration of the drug, including sterile conditions and storage

_____

Adverse reactions that should be reported to the prescriber_____

_____

Prescriber's Signature_____ Telephone_____

Printed/Typed Name_____ Date_____

*Parent, guardian, or other person having care or charge of the student.

11/05
10/06
7/07