This form only needs to be returned if your child takes medicine that must be administered during the school day.

BISHOP LEIBOLD SCHOOL
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

****This form must be completed by the physician even for over-the-counter medications****
As required by Section 3313.713 Ohio Revised Code

Name of Student ______________________ Date of Birth ______________

Address ______________ School ______________ Grade/Teacher ______________

PARENT/GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your children then sign this section:

1. Both the parent (top section) and the licensed prescriber (bottom section) must complete this form.

2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication). The prescription label must match the instructions for the prescriber. If it is a non-prescription medication, it must be in the original container.

3. **ALL MEDICATIONS MUST BE BROUGHT TO SCHOOL BY PARENT/GUARDIAN, NOT BY THE STUDENT**.

4. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.).

IMPORTANT:

The medication for the student listed below cannot be scheduled for other than school hours. I am fully aware that such requested medication may be, by necessity, administered under the supervision of medically unlicensed personnel (OAC 4723-13-02) when the school nurse is not present. With this in mind, I request that the medication as indicated on the other side, be administered by school personnel who have been trained by the school nurse to administer oral medications, eye drops, inhalers, insulin, and some medications necessary for in emergency situations (such as an Epi-pen.)

As the parent/guardian of this student, I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medications. I request that this medication be administered to my son/daughter according to the directions of the licensed prescriber in the following 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.

Signature of Parent/Guardian ______________________ DATE ______________

(over)

LICENSED PRESCRIBER SECTION

I verify that this medication must be taken by: ____

Name of Student / Date of Birth

Diagnosis for which this medication is prescribed____

_____________________________ _____________________________ _____________________________

Medication Strength Dose/Time

_____________________________ _____________________________ _____________________________

Time medication is to be taken Administration start date Expiration date

Instructions or precautions, including possible side effects: ____

____

____

____ _____________________________

Licensed prescriber signature Date

____ _____________________________

Licensed prescriber printed name Telephone Number

==

MEDICATION LOG FOR _______ SCHOOL YEAR

MEDICATION NAME:_____________________ **DOSAGE: _________________**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar.																															
April																															
May																															
June																															

--------------------------- ------------------------- ----------------------------

Initials/Signature Initials/Signature Initials/Signature

Comments/Special instructions:____

____

____

____

Key: Initials = Medication taken within 1 hour of designated time.
O = no medication available
X = no school
A = absent
er = error

2011-12