Bethany School
555 Albion Avenue, Cincinnati, OH 45246
Phone: 513-771-7462
Fax: 513-771-2292

ADMINISTRATION OF MEDICATION

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any **prescribed or over-the-counter** medication to a student. Please complete this form and return to the school office.

Name of Student _____ DOB _____ Grade _____ Homeroom _____

Address _____ Telephone _____

Allergies _____

To be completed by LICENSED PRESCRIBER

In accordance with ORC 3313.713/ 3313.716 The Licensed Prescriber must provide the following information before a student is allowed to receive medication at school or possess and self-administer an asthma inhaler.

Condition for which medication is administered _____

Name of medication, dose and route _____

Time or indication for administration _____

Possible side effects to be noted/reported _____

Special Instructions _____Effective Date _____ Expiration date _____

For EPIPENS, INHALERS, AND INSULIN PUMPS – In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. YES _____ (initials) NO _____ (initials)

The following section is REQUIRED for EPIPENS, INHALERS that a student is carrying and self-administering, and is OPTIONAL for other medications:

- Instructions to follow in the event medication does not produce expected relief _____
  _____

_____ _____
Licensed Prescriber Signature Print Name

____/____/____ _____ _____
Date Phone Number; Fax Number

To be completed by PARENT/GUARDIAN

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.
2. Submit to school personnel a written statement when medication has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child to comply with medication administration instructions.
5. All medications must come to school in the original container from the pharmacist.
6. Parent requests medication to be:_____ picked up by parent _____ send home with student_____ destroy

_____ ____/____/____ _____
Parent//Guardian Signature Date Daytime Phone Number

For EPIPENS, INHALERS, AND INSULIN PUMPS – In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. YES _____ (initials) NO _____ (initials)

**** THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR****