ROSSFORD SCHOOL DISTRICT

Authorization for the Administration of Medication by School Personnel (as required by Section 3314.713 Ohio Revised Code)

The following information is necessary for any student to use prescribed medications or to receive treatment in school. All spaces must be completed.

_____ _____
Student's Name Date of Birth

_____
Address, City, State, Zip

_____ _____ _____
School Grade Teacher

PARENT/GUARDIAN SECTION
Please review the following steps required for permission of school personnel to administer any medication to your child and 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 prescription label must match the instructions from the prescriber. If it is a non-prescribed medication, it must be in the **original** container. **All medications must be within their expiration date.**
3. 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 dosage, time, etc.).
4. I will assume responsibility for safe delivery of medication/drug to school. 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.
5. 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.

I request that 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 (Parent, guardian, or other person having care or charge of the student) Date

_____ _____
Home Telephone Work Telephone

LICENSED PRESCRIBER SECTION
I verify that this medication must be taken by: _____
Name of Student

_____
Diagnosis for which medication is prescribed

_____ _____
Medication Dosage

_____ _____ _____
Time medication is to be taken/interval Administration start date Expiration date

Instructions or precautions:_____

Side effects of medication:_____

Side effects to report to prescriber: _____

_____ _____
Licensed prescriber signature Date

_____ _____
Licensed prescriber signature Date