

SCHOOL MEDICATION PERMIT
For Lakota East Bands Only

(In accordance with Ohio Revised Code 3313.713) The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This section to be completed by the Parent or Guardian

Name of Student: _____ **Birthdate:** _____

Student's Address: _____

School: _____ **Grade:** _____ **Homeroom:** _____

I request the school personnel administer the medication as instructed and I agree to **1)** Deliver the medication in the original container and **2)** Notify the school if I change physician's or medication is changed/eliminated.

I understand it is the student's responsibility to report on time for this medication. I agree to hold school employees/volunteers and the Board of Education free of responsibility to results of this medication.

If physician orders that the student carry an asthma inhaler for self-administration:

- 1) Provide a second inhaler to be stored in the clinic in the event the student doesn't have his/hers
- 2) Student should be responsible to report use of inhaler to nurse for assessment of effectiveness

Parent/Guardian Signature: _____ **Date:** _____

Phone # During School/Daytime Hours: _____ **Other Phone:** _____

This section to be completed by the Physician

Medication: Ibuprofen 200mg tablets, Extra Strength Tylenol, Benadryl 25mg, Sudafed Sinus, loperamide (Imodium AD), Tums EX, and/or Triple Antibiotic Cream.

Dosage to be given: As Directed on package **Time(s) to be given:** As Directed on package

Date of Authorization: _____ **Date to Begin:** August 1, 2009 **Date to End:** June 6, 2010

Adverse Reactions to be reported: _____

Special Instructions: _____

Administration: _____ *Storage:* _____ *Other:* _____

If physician orders student carry an asthma inhaler for self-administration, complete this section:

Procedure to follow if asthma symptoms are not relieved: _____

Adverse reaction if used by unauthorized person: _____

This patient has been instructed the proper use of this medication, the expected results and the possible side effects, and is capable of carrying and self administering this medication.

Physician Name (print please): _____

Physician Address: _____

Physician Signature: _____

Physician Emergency Phone #: _____ **Alternate Phone:** _____

This section for School Use Only

The following personnel/volunteers have read this form and are authorized to administer medication as outlined above:

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____