Saint Peter in Chains School
Phone: 863-0685
Fax: 863-1859

PERMIT FOR DISPENSING OVER-THE-COUNTER AND PRESCRIPTION MEDICATION

In accordance with Ohio Revised Code 3313.713
Required each school year and at any changes of medication.
The use of medication during school hours is discouraged. Use this form if it is essential for a student to receive medication during the school day.

THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student_____ Date of Birth _____
Student's Address _____
School _____Grade _____ Home Room _____

A. I am requesting permission for my child named above to: (Check all that apply)
   _____ use or receive prescribed medication.
   _____ receive prescribed treatment
   _____ self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the authorized prescription.
B. I will assume responsibility for the medication being delivered to the school office by an adult. The medication must be received in it's original over-the-counter or prescription container, labeled with the student's name.
C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. (You must submit to the school a written statement from the physician, 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, unforeseeable for damages or injury resulting directly or indirectly from this authorization.

* If the licensed provider authorizes that the student possess and use an asthma inhaler and/or an epinephrine autoinjector:

- Parent/Guardian will provide a backup dose of the medication (Epinephrine) to the school principal or nurse as required by law.
- It is strongly recommended that parent/Guardian provide a second inhaler to be stored in the clinic in the event that the student does not have his/her inhaler.
- The student should be responsible to report use of inhaler to the nurse and/or principal.

Parent/Guardian Signature _____ Date _____
Phone during school _____Other phone _____ Cell phone _____

THIS SECTION TO BE COMPLETED BY LICENSED PRESCRIBER

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student.

Medication _____ Date of Authorization _____
Dosage _____ Time(s) to be given _____ Start Date _____ End Date _____
Adverse reactions to be reported _____
Diagnosis _____
Licensed prescriber emergency telephone _____ Alternate telephone _____
Special Instructions _____
Administration _____
Storage _____
Other _____
Prescriber name (print) _____ Signature _____
Prescriber address _____

FOR SCHOOL USE ONLY

The following school personnel have read this form and are authorized to administer the medication as outlined:
Nurse's Signature _____ Date _____
Principal's Signature _____ Date _____
*Copies must be provided to Principal and School Nurses assigned to the student's building. Teachers should be notified of student carrying Asthma Inhaler or Epinephrine Autoinjector.