Revised 06/2020

NORTHRIDGE POLAR BEARS HEALTH SERVICES

PERMIT TO ADMINISTER MEDICATIONS

(IN ACCORDANCE WITH OHIO REVISED CODE 3313.713)

The use of medication during school hours is discouraged. Use this form only when it is essential for a student to receive medication during the school day.

PART I - to be completed by PARENT/GUARDIAN

Student Name _____ Student Date of Birth_____

Student Address_____

School _____ Grade_____ Teacher_____

I request school personnel administer medication as instructed and agree to notify the school in the event the medication is changed or eliminated. I will deliver the meication to the school in the **original container** and understand that **medications are not to be transported to school by my child.**

Parent /Guardian Signature_____ Date_____

Telephone During School Hours _____

PART II - to be completed by PHYSICIAN

Mediation _____

Dosage_____ Time(s) To Be Given_____

Date To Be Given_____ Date to End_____

Possible Adverse Reactions:_____

Special Instructions _____

Physician Name (Print)_____ Phone Number _____

Physician Address _____

Physician Signature _____ Date _____

PART III - to be completed by PHYSICIAN AND PARENT (if necessary)

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

The above named student has my permission to possess and self-administer the following medication at school (check applicable):

_____ Asthma Inhaler

_____ Emergency Auto-Injectable Medication

By checking the labeled line above, I acknowledge that I have deemed the student capable of possession and self-adminstration of the above name medication and have provided this student with proper training.

Special Instructions_____

_____

Physician Signature_____ Date_____

I authorize my child to possess and use the above named medication at school or school-sponsored event and understand that school personnel will notify emergency medical services immediately should an Emergency Auto-Injectable Medication be administered.

Parent Signature_____ Date_____

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