Vermilion Local Schools
Administration of Medication at School

School policy requires consent of the parent/guardian and a written statement from a licensed prescriber before school personnel can give medication to a student. The following information is necessary in order to comply with this policy. Return the completed form to the school office.

Student Name _____ DOB_____ Grade_____
Address_____ Phone_____

Physician Name_____ Phone_____
Physician Address_____

To be Completed by Prescribing Physician or his/her Designee

General Medication Administration

Diagnosis_____
Medication_____ Dosage_____
Time or Interval of Dosage_____
Start Date_____ End Date_____
Special Instructions (sterile conditions & storage) _____
List any Severe Adverse Reactions that Should be Reported to Physician
_____
_____

Physician Signature _____ Date_____

Asthma Inhaler or EPI Pen

Diagnosis_____
Medication_____ Dosage_____
Time or interval of dosage_____
Start Date_____ End Date_____
Special instructions (sterile conditions & storage)
_____
List any severe adverse reactions that should be reported to physician
_____
_____
Medical authorization for student to carry inhaler or EPI pen _____Yes _____No
Prescriber has determined that the student is capable of possessing & using appropriately _____Yes ____No
Prescriber has trained the student in the proper use _____Yes _____No
Procedure to follow in the event that the inhaler or EPI pen does not produce relief
_____
_____

***If the student is to possess an EPI pen for self-injection, a second back up pen MUST be in the possession of school staff (nurse). (ORC 3313.718)**

Physician Signature _____ Date_____

****Complete Reverse for Active Seizure Disorder****

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To be Completed by Prescribing Physician or his/her Designee

Active Seizure Disorder

Diagnosis_____

Is the student prescribed medication _____Yes _____No (if no proceed to signature)

If "YES" complete the information below

Maintenance Medication_____

Dosage_____

Time or Interval of Dosage_____

Start Date_____ End Date_____

Special Instructions (sterile conditions & storage) _____

List any Severe Adverse Reactions that Should be Reported to Physician _____

_____

Rescue Medication_____

Dosage_____

Time or Interval of Dosage_____

Start Date_____ End Date_____

Special Instructions (sterile conditions & storage) _____

List any Severe Adverse Reactions that Should be Reported to Physician _____

_____

Physician Signature _____ Date_____

Parent

Medication must come to school in the original container with the affixed label from the pharmacist. The label must show:

- **The student's name**
- **Name of the medication**
- **Dosage directions**
- **Licensed prescriber's name**
- **Rx number (if there is one)**

I request that medication be administered as instructed by my child's physician/dentist. I understand that a new form must be submitted each school year and whenever the medication or dosage is changed. I am required by Ohio law to provide the school with the medication in the original container as dispensed by the pharmacist.

I release and agree to hold the Vermilion Local Schools Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____ _____

Parent Signature Date Parent Emergency Phone Number