Jefferson Township Local Schools
School Health Services

Blairwood Elementary, 1241 Blairwood Drive, Dayton, Ohio
Phone: 937-263-3504 Fax: 937-262-3450

MEDICATION ADMINISTRATION

PHYSICIAN'S REQUEST FOR JEFFERSON TWP LOCAL SCHOOLS PERSONNEL

All parents who wish to have any type of medication including non-prescription drugs administered to their school age child must submit to the school written authorization signed by both the physician and parent. These permission slips are available from the school office or clinic. We apologize for any inconvenience this might cause, but with wide spread concern over the abuse of drugs and the need to insure that all medications are administered correctly and as intended, we must ask your cooperation in complying with the state law (OHIO REVISED CODE Section 3313.713).

PLEASE SEND THE MEDICATION IN THE ORIGINAL CONTAINER WITH THE PRESCRIPTION LABEL ON IT.

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION

_____ _____
Student's Name School

Is under my care and should be administered the medication:

Name of Medication _____ Times to be given or Intervals _____

Dosage _____ Special Instructions _____

Beginning on (date) _____ Ending on (date) _____

Possible severe adverse reactions that should be reported to the physician: _____
_____

Physician's Name (Print) _____ Phone Number _____
Address _____

Physician's Signature _____ Date _____

TO BE COMPLETED BY PARENT OR GUARDIAN

We (I) understand that the administration of this medication is to be done under the supervision of the School Nurse or designated personnel assigned by the administrators. Further, we (I) understand that the school personnel are not legally obligated to administer any medication to a child and therefore, we (I) agree to release and waive all claims against the School District and its employees from any and all bodily injury or death resulting from such medication or the manner in which it is administered. Further, we (I) agree to deliver the medication to the school in the original container from the prescribing physician and properly labeled by the licensed pharmacist. This label is to include name of student, physician, date, dosage instructions, name of medication and expiration date. Further, we (I) will notify the school immediately if we (I) change physician or medication or terminate the use of this medication for any reason.

_____ _____
Signature of Parent/Guardian Date -