



**Madison Local School District**

**PERMIT FOR ADMINISTERING PRESCRIPTION MEDICATION**

(In accordance with Ohio Revised Code 3313.713)

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/GUARDIAN**

Name of Student \_\_\_\_\_ Birth Date \_\_\_\_\_

Student's Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

School \_\_\_\_\_ Class/Grade \_\_\_\_\_

*I request school personnel to administer the medication as instructed and agree to notify the school if I change physicians or if the medication is changed or eliminated. I will deliver the medication to the school in the original container and understand the medication is not to be transported by my child. I understand that it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility resulting from use of this medication.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone during school hours \_\_\_\_\_ Other phone \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY THE PHYSICIAN**

Medication \_\_\_\_\_ Date of Authorization \_\_\_\_\_

Dosage \_\_\_\_\_ Special Instructions \_\_\_\_\_

Time(s) to be given \_\_\_\_\_

Date to begin \_\_\_\_\_ Date to end \_\_\_\_\_

Adverse reactions to be reported \_\_\_\_\_

**FOR ASTHMATIC STUDENTS – SELF-MEDICATION BY INHALER**

Student should keep inhaler on person YES NO

Adverse reactions for unauthorized use of inhaler \_\_\_\_\_

Procedure to follow in the event the medication does not produce relief from asthma attack \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Physician's Signature \_\_\_\_\_

PLEASE PRINT

NO STAMPS

Physician's Emergency Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_