St. Vivian Catholic School
885 Denier Place Cincinnati, OH 45224 • 513.522.6858 - office • 513.728.4336 - fax

ADMINISTRATION OF MEDICATION (form expires at end of school year)

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any prescribed or over-the-counter medication to a student. Please complete this form and return to the school office.

Student Name:_____ DOB:____/____/____ Grade:_____

Address:_____ Phone:_____

Allergies? Y / N If yes, Please list: _____

TO BE COMPLETED BY A LICENSED PROVIDER

In accordance with ORC 3313.713/3313.716 The licensed Prescriber must provide the following information before a student is allowed to receive medication at school or possess & administer an asthma inhaler.

Condition for which medication is administered: _____

Name, Dose & Route of Medication: _____

Time or Indication for administration: _____

Possible side effects: _____

Special Instructions: _____

Effective Date:_____ Expiration Date of this Request: _____

FOR ASTHMA INHALERS & INSULIN PUMPS

It is my opinion that the child shows the ability to administer and be responsible for carrying & self-administering the above medications. YES_____(initial) NO_____(initial)

Required for ASTHMA INHALERS carried & self-administered by child / Optional instructions for other Medications

Instructions if medication does not produce expected relief:_____

_____

_____

Possible side effect for medication child is not prescribed should he/she receive a dose: _____

_____

Licensed Provider Name (print): _____ Signature: _____

Date: ____/____/_____ Phone: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for the school to administer the medication above to my child, and agree to 1. Submit a revised statement signed by the prescriber if any change in the original statement occurs. 2. Submit to school a written statement when medication has been discontinued. 3. Grant permission to the school nurse to confer with the above licensed prescriber regarding health & treatment issues as they pertain to above medication and educational/behavioural management needs. 4. Cooperate with school personnel in assisting my child to comply with medication administration instructions. 5. Understand all medication must be delivered to school by the parent/guardian, in the original container from the pharmacist. OTC medication must be unopened with child's name on the container.

Signature: _____ *Date:* ____/____/____ *Phone:* _____

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