Tri-Valley Local Schools

In accordance with ORC 3313.713

Authorization for Administration of Prescribed Medication or Treatment

This section must be completed by and signed by the parent/guardian. A completed form must be provided to the school principal and/or nurse before prescribed medication/treatment may be administered to the student. Medication must be administered by an authorized medication administrator/nurse in the office or clinic. ONE medication may be listed per medication form.

Student Name	Address	
School	Grade	Birthdate

As the parent/guardian of this student, I authorize my child to use prescribed medication/treatment per physician's order, at the school and any activity, event, or program sponsored by the school. The medication must be in the orignial container and be properly labeled with the students name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration.

I will assume responsibility for safe delivery of the medication to the school.

I will notify the school immediately if there is any change in the use of the medication or prescribed treatment.

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

Parent/Guardian Signature	Date
Parent/Guardian Name Printed	Parent/Guardian Emergency Telephone #

This section must be completed by the student's physician.

Name and dosage of medication. Times or intervals to administer medication.

Date medication administraton begins:	Date medication administraton ends:

Procedures for school employees if the medication does not provide the expected relief:

Special instructions for administration of the medication including sterile conditions and storage:

Possible severe adverse reactions:

A. That may occur to student receiving the medication that should be reported to the prescriber:

B. That may occur to another student for whom the medication is not prescribed, should such a student receive a dose of the medication:

Physician signature	Date
Physician Name Printed	Physician Emergency Phone Number

Office use only: Medication will be administered by staff listed on medication administration designation list.

Reviewed by authorized medication administrator ____

DASL Entry ____ Reviewed by Nurse _____

Original Order to Nurse ____ Date _____