WEST SIDE PEDIATRICS

663 Anderson Ferry Road
Cincinnati, Ohio 45238

7074 Harrison Ave
Cincinnati, Ohio 45247

Telephone 513-922-8200
Fax 513-347-2407

ADMINISTRATION OF MEDICATION AT SCHOOL

School policy requires consent of the parent/legal guardian and a 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 it to the school office.

Name of Student ____ DOB _____/_____/_____Grade ______Home Room ______

Address ____Telephone_________________________________

Allergies ____

TO BE COMPLETED BY LICENSED PRESCRIBER

Condition for which medication is administered: ____

Name of medication, dose and route: ____

Time or indication for administration: ____

Specific instructions for administration: ____

Possible side effects to be noted/reported: ____

Effective date _____/_____/_____ ☐ Date signed Expiration date of this request _____/_____/_____ ☐ End of school year

FOR ASTHMA INHALERS, EPI-PENS, INSULIN PUMPS — In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. Yes ☐ No ☐

Instructions to follow in the event medication does not produce expected relief: ☐ Give 2 more puffs and contact parent

☐ Follow Asthma Emergency Action Plan (attached) ☐ If child does not respond and is in severe distress, call 911.

____ ____

Licensed Prescriber's Signature Print Name

______/_____/_____ ____

Date Phone Number

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to:

1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original medication statement occurs.
2. Submit to school personnel a written statement when the medication has been discontinued. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
3. Cooperate with school personnel in assisting my child to comply with medication administration instructions.
4. ALL medications must come to school in the original container from the pharmacist.

For INHALERS, EPI-PENS AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, demonstrates proper administration, and has shown responsible behavior when it comes to carrying this medication. I further understand that my child will demonstrate proper administration and sign a contract stating that he/she will be responsible for the medication during school.

Yes ☐ No ☐ Initials __________

____ ______/______/______ ___________________________________

Parent/Guardian Signature Date Daytime Phone Number

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR