Bay Village City School District

**PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A PRESCRIBED MEDICATION/DRUG OR TREATMENT**
**(Grades K-12)**

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____
Name of Student Address

_____
School/Grade/Teacher Phone

A. I am requesting permission for my child named above to:

_____ self-administer prescribed medication/s in my presence or that of an authorized staff member

_____ receive prescribed treatment

in accordance with the authorized prescription.

***B. I will bring the medication/drug to school in the original container in which it was dispensed by the licensed prescriber or by the licensed pharmacist.***

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

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

E. The State of Ohio allows students to carry inhalers, Epipens, or emergency medication such as insulin if the prescriber feels that it is necessary for the student to carry the medication, has taught the student the proper use of the medication, and the student has demonstrated to the prescriber the proper use of the medication.

_____
Signature of Parent/Guardian Date

_____
Home Telephone Work Telephone

Bay Village City School District

**LICENSED PRESCRIBER'S STATEMENT**

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

_____ _____
Name of Student Address

_____
School/Grade/Teacher Phone

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student (specify the name of the drug) :

_____

_____

Date the administration of the drug is to begin _____

Date the administration of the drug is to cease _____

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered:

_____

Specify any special instructions for administration of the drug, including sterile conditions and storage:

_____

Report the following side effects (i.e., severe adverse reactions) to my office immediately:

_____

Prescriber's Signature _____ Phone _____

Printed/Typed Name _____ Date _____

_____

_____ _____
Administrator's Signature Date
Or

_____
District Nurse Date