

(Other side to be completed by parents)

**KETTERING CITY SCHOOL DISTRICT
HEALTH SERVICES - STUDENT SERVICES**

LICENSED MEDICAL PROVIDER'S REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

To: Kettering City School Personnel

Medication for the student listed below cannot be scheduled for other than school hours, and the administration of such medication may be supervised by medically untrained personnel. It is requested that the medication as indicated below be administered by school personnel.

1. Name of student _____

2. Address of student _____

3. (a) School _____ (b) Grade _____

4. Medication to be administered (name, quantity, times and route) _____

5. Possible reactions that, if occur, should be reported to the licensed medical provider _____

6. Special instructions if required (administration of drug, sterile conditions and storage, etc.) _____

7. Medication to be continued as above until _____

(date)

8. Date of this request _____

9. Licensed medical provider's signature _____

10. Licensed medical provider's address _____

11. Licensed medical provider's emergency telephone number _____

To be completed by the school:

1. Person(s) authorized to administer medication for this student. (Principal should list name[s])

2. Nurse's signature _____ Date _____

3. Principal's signature _____ Date _____

(This side to be completed by parents)

KETTERING CITY SCHOOL DISTRICT
HEALTH SERVICES - STUDENT SERVICES

PARENT RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

To: _____, Principal, _____
(School name)

For: _____
(Student's name)

We (I), the undersigned, who are the parent(s), foster parent(s), guardian(s), (*cross out those not applicable*) of _____ request that medication be administered to our child in accordance with the _____ (student's name) instructions of our Licensed Medical Provider, _____ (see instructions on other side of this form). We (I), understand that the administration of said medication is to be done under the supervision of a member of the school staff.

Further, we (I), the undersigned, agree to bring the medication to school in a container from the pharmacist properly labeled by same, this label to include name of the student, licensed medical provider, date, dosage instructions (quantity and times), and name of medication.

Further, we (I), the undersigned, will notify the school immediately if we change medical provider or medication or terminate the use of this medication for any reason. When medication has been discontinued, any remaining medication must be picked up by the parent within 2 weeks after discontinuation or it will be discarded by school personnel. Parents must pick up medication on the last day of school or it will be discarded.

Signature of Parent _____

Address of Parent _____

Home telephone number _____ Business telephone number _____

(Other side, top section, to be completed by family licensed medical provider)