Kettering City School District

LICENSED MEDICAL PROVIDER'S REQUEST FOR DISPENSING PRESCRIPTION/NON-PRESCRIPTION MEDICATION AT SCHOOL

(In accordance with ORC 3313.713 and SUB S.B. No. 164)

Medication for the student listed below cannot be scheduled for other than school hours. The administration of such medication may be supervised by medically untrained personnel. It is requested that the medication as indicated be administered by school personnel. **A new form must be provided each school year.**

Student Name ______________________________ School ______________________________

Student address ______________________________ Grade ____________________

PART I: MEDICATION TO BE TAKEN – TO BE COMPLETED BY LICENSED MEDICAL PROVIDER

Name of Medication ____
One medication per form

Dose______________________________ Time to be given at school________________

Date administration is to: Begin____________________ End______________________
(End of school Year unless otherwise noted)

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

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

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Name of licensed medical provider__________________________________ Date____________________

Address of licensed medical provider____

Phone Number______________________ Emergency phone number____________________

Signature of licensed medical provider____

PART II: PERMISSION TO CARRY ASTHMA INHALER/EPI-PEN – TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

If requesting permission to carry an inhaler/epi-pen, the following must be completed in addition to Part I.

The law permits a student to carry an asthma inhaler/epi-pen with the consent of the student's licensed medical provider and parent.

As the prescriber, I have determined that this student is capable of possessing and using this inhaler/epi-pen (circle one) appropriately and have provided the student with training in the proper use of the inhaler/epi-pen. The student has been instructed to immediately notify a staff member or responsible adult when the epi-pen is used.

KCS policy states 911 will be called if the epi-pen is used.

Procedures to follow in the event that the **asthma inhaler/epi-pen** does not produce the expected relief.

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Signature of Licensed Medical Provider____

(OVER)

PART III: <u>PARENT RELEASE</u> FOR DISPENSING PRESCRIPTION/NON-PRESCRIPTION MEDICATION AT SCHOOL

To: ______________________________ ______________________________
Principal School Name

For: ______________________________
Student Name

We (I), the undersigned, who are the (CIRCLE ONE) parent(s), foster parent(s), guardian(s) of ______________________________ request that medication be administered to our child in
Student Name
accordance with the instructions of our Licensed Medical Provider, ______________________
(see instructions on other side of this form). **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 the school nurse. **Parent must pick up medication by close of the last day of school or it will be discarded.**

I give permission for this information to be sent to the school nurse via facsimile. I also authorize the exchange of information between the licensed medical provider and the school nurse regarding the health care needs of my student when deemed necessary by the school nurse.

Signature of Parent/Guardian: ______________________________ Date: ____________

Address: ____

Home Phone: ______________________ Work Phone: __________________________

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