AUTHORIZATION FOR PRESCRIPTION MEDICATION

Joseph Badger School District
7119 State Route 7, Kinsman, Ohio 44428 Phone: 330-876-2800 Fax: 330-876-2811

The following information is necessary for any student to receive physician-prescribed medication on school premises.

Student Name _____ Birthdate _____ Age_____

Grade _____ Teacher _____

1. I am requesting permission for my child named above to receive physician prescribed medication at school.
2. I will assume responsibility for the safe delivery of the medication to school for the initial and all subsequent doses, for maintaining adequate amounts of medication, and replacing it prior to its expiration date.
3. I will provide the school with a new Medication Authorization form if there is any change in the dosage or use of the medication, and I will notify the school in writing if the medication is discontinued. I understand that verbal notification is permissible followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.
4. I release and agree to hold the Board of Education, and its officials, and its employees harmless from any liability for damages or injury resulting directly or indirectly from this authorization, in accordance with the Medication Policy.

_____ _____

Signature of Parent/Guardian Relationship to Student

_____ _____ _____

Home Phone Work/Cell Phone Date

PHYSICIAN STATEMENT

To the physician:

The Board of Education urges you to schedule, to the extent possible, the administration of medication to a student outside of school hours. When this is not possible, medications will be permitted, insofar as feasible, during school hours. Please complete every space.

_____is under my care.
student name

I have prescribed _____
name of medication dosage route of administration time(s) to be given.

Beginning date_____ Ending date_____

Specific Instructions for administration _____

_____

Possible side effects to be alerted to _____

Specific instructions including storage/sterility_____

Allergies _____

Date _____ Telephone _____ Fax _____

Physician Printed/Typed Name_____

Physician Signature _____