

St. Albert the Great School
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 _____
_____ at School _____

PART I: MEDICATION TO BE TAKEN – TO BE COMPLETED BY A 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

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

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/EPINEPHRINE – TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

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

The law permits a student to carry an asthma inhaler/epinephrine 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/epinephrine (circle one) appropriately and have provided the student with training in the proper use of the inhaler/epinephrine. The student has been instructed to immediately notify a staff member or responsible adult when the epinephrine is used.

KCS policy states 911 will be called if the epinephrine is used.

Procedures to follow in the event that the **asthma inhaler/epinephrine** does not produce the expected relief:

Signature of Licensed Medical Provider _____

(OVER)

Kettering City School District

**PART III: PARENT RELEASE 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: _____

Office Use Only: (Medication Returned or Destroyed)

Date: _____ Amount: _____ Reason: _____

Signature #1: _____ Signature #2: _____