Student Photo ID

Cloverleaf Local Schools

PRESCRIPTION & OVER-THE-COUNTER MEDICATION FORM

Medication Administration by School Employees (O.R.C. 3313.713)

If you wish your child to receive **ANY** medication, Ohio law requires written permission from your health care provider and parent. This includes all prescriptions and/or over the counter medications. This written permission must be renewed annually. All non- prescription medications **MUST** be in a new unopened bottle. Each medication must have its own medication administration form. Medications are not to be combined on the same sheet.

***** DO NOT USE THIS FORM FOR ASTHMA, ALLERGY OR SEIZURE MEDICATIONS (see required health care plan)**

_____ _____ **CHS CMS CES School Grade and Year** _____

Student Name **DOB**

Name of the medication _____

Reason for medication _____

Dosage & route to be administered _____

Time each dosage is to be administered _____

Date the administration of medication is to begin _____

Date the administration of medication is to end _____

Adverse reactions that need reported to the physician _____

Telephone number that parent can be reached in an emergency _____

Any Special instructions for Administration of medication _____

_____ _____

Name of Physician **Phone** **Date**

Signature of Physician _____

(ALL MEDICATION MUST HAVE PHYSICIAN SIGNATURE)

I hereby request and give my permission to the principal, nurse or designee to administer the medication listed above to my child as instructed by physician. I specifically agree that if any information on the attached Medication Administration statement changes, I will immediately submit to the school nurse or building principal a new daily medication form completed and signed by parent and physician. Any school employee administering the medication described on the statement of the medication administration shall be entitled to rely upon the information therein contained until such time as a new form is submitted. All medication must be brought to the school in its original container and clearly labeled. If prescribed, the medication must be split prior to school receiving the medication. The medication will be kept secure in the school as directed.

_____ _____

Parent/Guardian Signature **Date**

High School	Middle School	Elementary School
Office: 330-302-0328	Office: 330-302-0207	Office: 330-302-0103
Fax: 330-302-0530	Fax: 330-302-0520	Fax: 330-302-0080