



Administration of Medication Form

Parent/Provider Request for School Personnel to Administer Medicine

School: _____ School Fax Number: _____

Cincinnati Board of Education policy, Section 5330, requires consent of the parent, guardian, or eligible student 18 years or older before medication (including prescription medication, inhalers, Epinephrine, etc.) can be given to a student by school personnel. The following information is necessary to comply with this policy. Please **answer all questions** and return this completed form to your student's principal or school nurse.

Student Name: _____ Date of Birth: _____ Home Phone: _____

TO BE COMPLETED BY THE STUDENT'S PROVIDER (Physician/Nurse Practitioner/Dentist)

Name of Medication: _____ Dosage: _____

Frequency: _____ How Administered: _____ Date to Begin Medication: _____

Permission for this medication is only valid through the end of the current school year. EXCEPTION: For emergency medications for asthma, anaphylaxis, seizures or diabetes, this permission can be valid for 3 years. A provider order is required for any changes in this medication.

Date to Terminate Emergency Medication: _____ (3 years)

Please attach an emergency action plan with procedures to be followed if emergency medication does not alleviate student's emergency.

For Epinephrine orders only: _____ I have determined that this student is capable of possessing and using this auto injector/epipen appropriately and have provided the student with training in the proper use of the auto-injector.

Possible side effects that should be reported to the physician: _____

Possible side effects to another student whom the medication is NOT prescribed who receives a dose: _____

Special conditions for storage of drug: _____

Provider's Signature: _____ Date: _____

Provider's Name: _____ Phone Number: _____

TO BE COMPLETED BY THE STUDENT'S PARENT OR ELIGIBLE STUDENT

The medicine must be in pill, capsule, liquid, auto-injector or inhaler form; and must be clearly marked from the pharmacist. The label must show the student's name, medication name, dosage directions, doctor, and prescription number.

Pharmacy: _____ Phone Number: _____

As the parent/guardian of this student (or eligible student), I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.

Please check the following if applicable:

For Students with Asthma:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student (or myself) to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school participates

For Students with EpiPen/Twinject/Auto Injector:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student to possess and use an Epinephrine Auto-Injector, as prescribed, at the school and any activity, event, or program in which the student's school participates. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. **I will provide a backup dose of the medication to the school as required by law.**

Name of Parent/Guardian/Eligible Student (please print): _____

Signature of Parent/Guardian/Eligible Student: _____ Date: _____

Primary Emergency Phone: _____ Secondary Emergency Phone: _____