School Year ___________

Washington Local Schools

3505 W. Lincolnshire Blvd.
Toledo, Ohio 43606

Administration of Medication or Treatment

A completed form must be on file before medication or treatment will be administered to a student during school hours. *A licensed prescriber must authorize both over-the-counter and prescribed medications as well as any treatment(s).* A form must be completed for each medication or treatment prescribed.

Student Name ________________________________ Birth Date ___________

Parent Name ____

Phone ________________ Address____________________________________

School ____ Grade________

To Be Completed By Parent

The parent signing below:

1. Requests and gives permission to the principal, school nurse or a trained designee to administer the medication / treatment described on the back of this form.
2. Will personally deliver or arrange for a responsible adult to deliver medication to the school.
3. Will personally pick up or arrange for a responsible adult to pick up unused medication.
4. Will notify the school if the medication, dosage, or treatment procedure is changed or if it is to be eliminated.
5. Will not hold liable Washington Local Schools personnel trained in the administration of the medication or treatment for administering or failing to administer the medication or treatment.
6. **For asthma medication inhalers**: I authorize my child to possess and use an inhaler , as prescribed, at school and any activity, event or program sponsored by or in which the student's school is a participant.
7. **For epinephrine autoinjectors**: I authorize my child to possess and use an epinephrine autoinjector as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. **I WILL PROVIDE A BACKUP DOSE OF THE MEDICATION TO THE SCHOOL PRINCIPAL OR SCHOOL NURSE AS REQUIRED BY LAW.**

Parent/Guardian Signature _______________________________Date____________

Parent/Guardian Name (Print) ____

Licensed Prescriber's section on the back

Student Name ________________________________ **Birth Date**___________

TO BE COMPLETED BY THE LICENSED PRESCRIBER (i.e. Physician, etc)

Name of Medication or Treatment ____

Purpose of Medication or Treatment _______________________________________

____

Dosage __________________Time to be given at school _____________________

Method of Administration ____

Date Medication Administration Begins ________________Ends_______________

Adverse reactions to the student for which it is prescribed that should be reported to the Prescriber ____

Student with Inhaler
Is student able to carry inhaler and self-administer inhaler? ___Yes ___No

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FOR EPINEPHRINE AUTOINJECTORS
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief ________________________

____

Possible severe adverse reactions to a student for which the medication is **NOT** prescribed who receives a dose____

____

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

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Licensed Prescriber Name________________________________**Date**_____________
(i.e. Physician, etc)
Prescriber Signature____

Prescriber Emergency Telephone Number____________________________________

Revised February 2010
Please return to student's school after completion via parent, mail, or facsimile.
School's fax number_______________________