This form meets state requirements for general medication administration at school. (ORC – 3313.713) It is not appropriate for ordering asthma inhaler or epipen.

PHYSICIAN/AUTHORIZED PRESCRIBER REQUEST TO ADMINISTER MEDICATION AT SCHOOL (Saint Ignatius High School – Fax 216-651-6313)

Student Name: _____ **Birthdate:** _____**Grade:**_____

Address:_____Telephone:_____

ONLY ONE MEDICATION PER FORM

Medical Diagnosis/ Reason for Medication at School:_____

Name/strength of medication: _____

Form (Tablet, Liquid, etc.)	Dose	Route	Frequency (Daily, PRN, etc.)	Time(s) at school

Restrictions/side effects or special instructions: _____

_____

Start date: _____ **End date:** ☐ End of school year or ☐ _____

Medications/doses at home:_____
(List all that apply)

_____

_____ _____
Physician/Authorized Prescriber Signature **Date**

_____ _____
Printed Name **Telephone**

PARENTS REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION AT SCHOOL

I give permission for my child,_____, to receive the above medication at school according to the prescriber's order and school policy. It is understood that Saint Ignatius High School and all of its personnel are absolved from any liability which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. I give permission to the School Nurse to communicate with the prescriber regarding my child's treatment plan.

_____ _____ _____
Parent/Guardian Signature Date Telephone (work /cell/ emergency)

Reviewed by Nurse (name):_____date:_____

Revised 2/12