HUBER HEIGHTS CITY SCHOOLS

900.42
10/12/16

MEDICATION ADMINISTRATION REQUEST AT SCHOOL

Part I – TO BE COMPLETED BY PHYSICIAN

Name of Student _____ Date of Birth _____

Address of Student _____

School Building _____ Principal _____ Grade ____ Teacher/Room# _____

Name of medication to be administered:_____

Reason student is taking medication:_____

Quantity (dosage) _____ Times _____ Date to Begin _____ Date to End _____

Possible reaction that should be reported to physician: _____

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

YES ____ NO _____ This student may self administer for field trips-Inhalers only

Physician's Name (please print) _____

Physician's Address _____
(Street) (City) (Zip Code)

NPI# _____ Physician's Phone No. _____ Physician's Fax No. _____

Physician's Signature _____ Date _____

Part II – TO BE COMPLETED BY PARENT(S), FOSTER PARENT(S), OR GUARDIAN(S) **

WE (I) understand that the administration of said medications/procedure is to be done under the supervision of a medically untrained member of the adult school staff.

FURTHER, we (I) understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) agree to hold the school district and any and all of its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against any loss or expense incurred arising out of these arrangements, including any civil judgment which may be rendered against them.

FURTHER, we (I) agree to deliver the medication to the school in the original container from the prescribing physician or licensed pharmacist, properly labeled by same, this label to include name of student, physician, date, dosage instructions (quantity and times), and name of medication.

FURTHER, we (I) will notify the school immediately if we change physicians or terminate the use of this medication for any reason, and we will report immediately to the school to pick up the remainder of said medication.

FURTHER, we (I) give permission for nurse to confer with physician regarding any questions regarding this medication.

FURTHER, we understand medication not picked up at end of school year will be disposed.

Signature of father or guardian _____ Date _____

Signature of mother or guardian _____ Date _____

Address_____ Home Phone _____

Work Phone: _____ Cell Phone: _____ E-mail: _____

Part III – TO BE COMPLETED BY THE SCHOOL

Signature of Principal/Nurse: _____ Date: _____

**Both parents must sign this release if they are living with or have custody of the child. If parents are separated and both still retain legal custody, both parents must sign. If child is in a foster home and placement is by agency that holds custody, agency representative must sign.

PLEASE RETURN THIS FORM TO THE SCHOOL CLINIC