

Mariemont City School
Administration of Medication Year _____

School policy requires consent of the parent/legal guardian and **written statement from the licensed prescriber** before school personnel can give **any prescribed or over the counter medication** to a student. Please complete the form in full and return to the school office. Failure to complete this form as requested will prevent your student from receiving medication at school.

Name of Student _____ DOB _____ Grade _____ Homeroom _____

Address _____ Telephone _____

Allergies _____ Date (From) _____ (To) _____

To be completed by Physician/Licensed Prescriber Only

Diagnosis:	Diagnosis:	Diagnosis:	Diagnosis:
Medication:	Medication:	Medication:	Medication:
Dose:	Dose:	Dose:	Dose:
Route:	Route:	Route:	Route:
Time:	Time:	Time:	Time:
Special Instructions:	Special Instructions:	Special Instructions:	Special Instructions:
If medication does not produce Expected relief:	If medication does not Produce expected relief:	If medication does not produce Expected relief:	If medication does not produce Expected relief:

For **ASTHMA INHALERS, EPI-PENS, INSULIN PUMPS**- In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. Yes _____ No _____ (**physician initial please**)
Physician states that there have been no recent changes in medications above. _____ (**initial please**).

 Licensed prescriber signature

 Print Name

Date: _____ phone: _____

To be completed by PARENT/GUARDIAN
 (initial by each statement as acknowledgement of terms)

I give permission for the principal or his /her designees to administer the medication above as prescribed by the physician to my child and further agree to:

1. Submit to school personnel a revised statement signed by the licensed prescriber above, when there are any changes in medications, dosages, times, routes, or diagnosis. _____
2. Submit to school personnel a written statement by the above prescriber when a medication has been discontinued. _____
3. Grant permission for the school nurse to confer with above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs. _____
4. Cooperate with school personnel in assisting my child to comply with medication administration instructions. _____
5. **All medication will be safely transported in the original container from the pharmacist by the parents.** _____
6. Release Mariemont City Schools from any liability concerning the administration or non-administration of the above Medication(s) to the student.

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