Mariemont City School District Administration of Medication
School Year: _____/Building: _____

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. If student will be **carrying** an **Epi-Pen or Asthma Inhaler**, completion of the "Authorization for Student Posession" form must be completed instead.

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: **If medication does not produce Expected relief:**	**Special Instructions:** **If medication does not Produce expected relief:**	**Special Instructions:** **If medication does not produce Expected relief:**	**Special Instructions:** **If medication does not produce Expected relief:**

_____ _____

Licensed prescriber signature **Print Name**

Date:_____ phone:_____ emergency 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.

_____ _____ _____ _____

Parent/guardian signature date daytime phone home phone

Any medication not claimed by the last day of school will be destroyed. This form expires at the end of each school year.

Created 1-08

<u>Medication administration Log</u>

Name____DOB_____________ Grade_______

Allergies____ Year_________________________

MEDICATION______________________ DOSE_____________TIME____________	MEDICATION______________________ DOSE_______________TIME__________	MEDICATION___________________ DOSE_____________TIME__________	MEDICATION_________________ DOSE___________TIME___________

DATE	TIME	AMT	NG	INITIALS	DATE	TIME	AMT	NG	INITIALS	DATE	TIME	AMT	NG	INITIAL	DATE	TIME	AMT	NG	INTL

NG codes (not given): NM <u>(no medicine parent notified)</u> **R** (<u>refused/parent notified</u>) **E** (<u>early dismissal</u>)
A (<u>absent</u>) **FT** (<u>field trip</u>)

Initials Signature Initials Signature

_____ ___________________________ ______ ____________________________________

_____ __________________________ ______ ____________________________________

Created 1-08