TRI-COUNTY NORTH LOCAL SCHOOL DISTRICT

School Medication Permit

(In Accordance with Ohio Revised Code 3313.713)

The use of medication during school hours is discouraged. Return this completed form if medication is essential.

This section to be completed by the parent or guardian

STUDENT NAME_____ DOB_____
ADDRESS_____ CITY_____STATE_____ ZIP_____
BUILDING_____ GRADE_____ HOME ROOM _____

I request school personnel to administer the medication as instructed and agree to (1) deliver the medication to the school in the original container, and (2) notify the school if I change physicians o if the medication is changed or eliminated. I understand it is the student's responsibility to report t time for this medication. I agree to hold school employees and the Board of Education free from al responsibility for results of such medication.

Parent/Guardian Signature_____ Date_____
Phone # during school hours _____ Other Phone #_____

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(This section to be completed by physician)

Medication _____ Date of Authorization _____
Dosage _____ Time(s) to be given _____
Date to Begin _____ Date to End _____

Adverse reactions to be reported:

_____

_____

_____

Physician Emergency Telephone # _____Alternate Phone #_____

Special Instructions: Administration _____
Storage _____
Other _____

Prescribing Physician (Print) _____ Signature_____
Address_____ City_____ Zip_____

For School Use Only

The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature_____ Date_____
Signature_____ Date_____
Signature_____ Date_____