East Holmes Local Schools
FOSTERING THE LIGHT OF KNOWLEDGE
6108 CR 77, Millersburg, OH 44654
(330) 893-2610 · Fax (330) 893-2838 · www.eastholmes.k12.oh.us

Parent Request to Administer Medicine to Students

East Holmes Staff is not permitted to administer Over the Counter (OTC) medications or prescription medications without a physician's statement per Ohio General Assembly revised Legislation 3313.713.

If you wish for us to be able to administer any type of medications, you will have to complete the "**Authorization for Prescribed Medication/Drug or Treatment**" form and have your physician complete the "**Licensed Prescriber's Statement**" form (attached).

Parents will need to have their physician authorize OTC medications on an "as-needed" basis.

Appropriate person appointed by the building principal will supervise the secure and proper storage and dispensation of medications. All prescription drugs must be received in the original container in which it was dispensed by the prescribing physician. All OTC drugs must be received in the original bottle as well. The medication must be in the original container (child proof) and have an affixed label including the student's name, name of medication, doses, route of administration and the time of administration.

Parents will continue to have the authority to come to school to administer OTC and prescription medications.

It is the intent of East Holmes Local Schools to not replace common sense first aid practices for state imposed legislation. Cuts and scrapes are reduced to treatment with soap and water and students will not be permitted to bring OTC medications to school for us to administer without a pre-authorized medication treatment form. Please give careful consideration to what you would like to happen if your child has a headache or minor cuts and scrapes. Then complete a form pre-authorized by your physician or accept that you may need to wait for your child to get home to use OTC medications.

Please contact your building Principal and/or Secretary if you have any additional questions and concerns.

AUTHORIZATION FOR PRESCRIBED MEDICATION/DRUG OR TREATMENT

TO THE PARENT:

The following information is necessary for any student to use prescribed medications or to receive treatment in school. All spaces must be completed.

______________________________ ______________________________

Name of Student Address

______________________________ ______________________________

School Grade

A. I am requesting permission for my child named above to: (Check all that apply)

_____ Use or receive prescribed medication

_____ Receive prescribed treatment

_____ Self-administer prescribed medication(s) in my presence or that of an authorized staff member

_____ For student with diabetes only: self-administer diabetes care in accordance with Policy 5336

In accordance with the Doctor's prescription

B. I will assume responsibility for safe delivery of the medication/drug to the school, except for diabetes medication student is permitted to possess pursuant to Policy 5536.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly from this authorization.

______________________________ ______________________________

Signature of Parent Date

______________________________ ______________________________

Home Telephone # Secondary Phone #

LICENSED PRESCRIBER'S STATEMENT

TO THE PRESCRIBER:

The East Holmes Local School District requires that all of the following information be provided before it will administer medication or treatment to the student named on this form.

I have prescribed the following medication ______________________________

____

____

Administration Times ______________________________

Dosage, instruction or precautions (including possible side effects) ______________

____

____

____

____

Beginning Date ______________ Ending Date ______________

I have prescribed the following treatment ______________________________

____

____

____

____

Special instructions, including storage and sterile requirements ______________

____

____

____

____

Beginning Date ______________ Ending Date ______________

(continued on back)

For Student with Diabetes Only:

_____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

Prescriber's Signature	Date
Printed/Typed Name	Telephone Number

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s) and/or treatment(s):

Printed Name	Printed Name
Printed Name	Printed Name

Principal's Signature	Date
Printed Name	Building