South Range Local Schools

... a school family serving children and those who love them

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ALL MEDICATIONS TO BE ADMINISTERED AT SCHOOL REQUIRE A REQUST FORM SIGNED BY A LICENSED HEALTH PROFESSIONAL

Whenever possible, we encourage medication doses to be scheduled during non-school hours. For those students who need medication at school, the following is **required** by Ohio State Law, **must be completed and be on file before any medication can be given.**

OVER THE COUNTER MEDICATIONS/PRODUCTS

- In order for your student to be administered an approved OTC medication by a licensed health care professional, you must give consent either verbally, or by email or text. The list of approved OTC medications shall be kept on file in the Elementary Nurses Clinic.

SHORT TERM PRESCRIBED MEDICATION (15 school days or less)

- An Authorization for Medications to be Taken at School form must be completed by both parent/guardian AND a licensed health care professional with prescriptive authority.
- Medication must be in its original container from the dispensing pharmacy and labeled as follows:
  ~Student's name and address
  ~Name and strength of medication
  ~Time and method of administration
  ~Length of time/days to be given

LONG TERM PRESCRIBED MEDICATION (16 school days or more)

- Must meet all of the requirements for short term medication dosage plus additional detailed instructions are required from your licensed health care professional.

REMEMBER: ONLY ORAL MEDICATIONS CAN BE GIVEN BY NON-NURSE SCHOOL STAFF. EPI-PENS ARE THE ONLY EXCEPTIONS.

Thank you for your cooperation,

Kim Peterson
SRLSD School Nurses

Continued on the other side

Board of Education
Taylor Christian • Terri Lally • Amy White • Ralph Wince • Corey Yoakam

South Range Local School District

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT SCHOOL

The following section is to be completed by Parent/Guardian ONLY: (Please Print)

School________________________________ Fax#__________________ Grade_________

Student's Name____

Last First M.I.

Birth Date________________________ Gender__________________

Health Care Provider's Information:

______________________________ ______________________________ ____________________

Name Address Phone & Fax

I request that authorized persons at school assist my child in taking the medicine(s) or to oversee as my child self-administers the medication(s) described below. I also give my permission for exchange of information between the school district staff and the health care provider. I shall hold harmless and indemnify South Range Local School District and its employees against all claims, judgments or liabilities arising out of the administration or overseeing the administration of any medication.

______ _______________________________________ ____________________ ____________________

Date Parent/Guardian Signature Home Phone Emergency Phone

Further details of administering medications can be found in the South Range Local School District Board Policy Manual-Section JHCD

The following section is to be completed by the Health Care Provider: (Please Print)

I have determined that the medication named below is advisable during the school day.

Diagnosis for which medication is given:____

Name of medicine:____________________________________ Dosage:________________

____Tablet/Capsule ___Liquid ___Inhaler ___Injection ___Nebulizer ___Other

If medicine is to be given DAILY, at what time?_______________________________________

If medicine is to be given WHEN NEEDED, describe indications: _________________________

____

How soon can it be repeated?____

Is the child authorized to medicate himself/herself? ____Yes ____No

If "yes" has the student been trained by a health care provider and is safe to self-administer?
____Yes ____No

Length of time this treatments is recommended:_______________________________________

Possible side effects:____

Emergency procedure in case of serious side effects:___________________________________

____________________ ____

Date Health Care Provider's Signature