

Medication Administration at School

When possible, medications should be given to students at home. However, if your child needs to take medication, prescription or over-the-counter, during the school day please follow the following guidelines:

- Please obtain a medication administration form from the school office. For prescription medication, the form must be completed by your child's physician, including the name, dose, and frequency of the medication and must also include the physician and parent's signature. For over-the-counter, the form must be completed and signed by the parent. (Cough drops are considered over-the-counter medication and must have a parent form)
- Once the form is completed please bring the medication to school in its original prescription labeled bottle or over-the-counter labeled bottle. Expired medication cannot be accepted. The student IS NOT permitted to bring any medication to school; this must be brought in by the parent, guardian, or designated adult.
- The medication will be stored in a locked container in the school office and the medication will be administered by the school nurse or other trained personnel.
- Any changes in medication or dosage will require a new written order from the physician.
- Parent/guardian must pick up medication at the end of the school year or when the medication has been discontinued. All unclaimed medication will be disposed of at the conclusion of the school year.
- Students who are prescribed emergency medications such as Epi-pens or inhalers may self-carry with written permission by their physician and parent.

If you have any questions about medications at school, please contact Missy Kemper, School Nurse at 740-678-2393 extension 3109.

Warren Local School District

220 Sweetapple Road, Vincent, OH 45784 Phone: 740-678-2366

Fax: Warren High School- 740-678-2783 Warren Elementary- 740-373-0517

Warren Middle School- 740-678-0118 Little Hocking Elementary- 740-989-2585

Authorization for the Administration of Medication by School Personnel

Non-Prescription/Over-the-Counter Medication

As required by Section 3313.713 of the Ohio Revised Code

Parent/Guardian:

Please review the following steps required for permission of school personnel to administer medication to your child.

- The parent must complete this form for non-prescription/over-the-counter medications.
- All non-prescription/over-the-counter medications must be in the original container.
- All medications must be brought to the school by a parent or guardian. Students **cannot** bring medications to school.
- New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in dose, time, etc.).
- Parents must pick up the remaining medication at the end of the school year.

I hereby request and give permission to the school nurse or school personnel designated by Board policy as authorized to administer medication, to administer the following non-prescription/over-the-counter medication to my child. I understand that I (parent or guardian) am responsible for the safe delivery of all medications to the school.

Name of student: _____

School: _____ Grade: _____

Name of medication: _____

Dosage: _____

Directions: _____

Specific time(s) to be administered: _____

Start Date: _____ End Date: _____

Possible side effects or adverse reactions of this medication are: _____

Signature of Parent or Guardian

Date

**Medication Administration Record (MAR)
General Medication Form**
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name		Date of birth	
Student address			
School	Grade/Class	Teacher	School year
List any known drug allergies/reactions		Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use		
Dosage	Route	Time/Interval	
Date to begin medication	Date to end medication		
Circumstances for use			
Special instructions			
Treatment in the event of an adverse reaction			
Epinephrine Autoinjector	<input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.		
Asthma Inhaler	<input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.		
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief			
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718			
a) To the student for whom it is prescribed (that should be reported to the prescriber)			
b) To a student for whom it is not prescribed who receives a dose			
Other medication instructions			
Does medication require refrigeration? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prescriber signature	Date	Phone	Fax
Prescriber name (print)			
Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.			

Parent/Guardian Authorization

<input checked="" type="checkbox"/> I authorize an employee of the school board to administer the above medication. <input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.			
<input checked="" type="checkbox"/> Medication form must be received by the principal, his/her designee, and/or the school nurse. <input checked="" type="checkbox"/> I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

<input type="checkbox"/> For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.			
<input type="checkbox"/> For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone