GRANDVIEW HEIGHTS CITY SCHOOL DISTRICT
REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

A SEPARATE FORM MUST BE COMPLETED FOR EACH MEDICATION

PHYSICIAN SECTION

Student's Name____

The above is under my care and should received the following medication:

Name of Medication____

Dosage____

Route____

Times____

Date First Dose to be Administered____________________________

Date Last Dose to be Administered____________________________

Possible Side Effects to watch for and report to physician________________________

____

Specific Instructions for administration (including authorization for self-administration of asthma inhalers, if appropriate)____

____

Specific instructions for storage____

____

PHYSICIAN'S SIGNATURE____

PHYSICIAN'S NAME (PRINT)____

OFFICE PHONE NUMBER____

DATE____

FOR SCHOOL USE ONLY:

I hereby certify that the above stated drug was received by me on ____________________ in what appeared to be the container in which it was dispensed by the prescribing physician or licensed pharmacist.

____

Signature of Person Authorized to Administer Medication

SEE NEXT PAGE FOR PARENT SECTION

GRANDVIEW HEIGHTS CITY SCHOOL DISTRICT
REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

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Student's Name___________________________________ DOB____________________

School____ Grade___________________

Homeroom/Advisory Teacher____

PARENT SECTION

I hereby request and give my permission to the principal and his/her designee to administer the medication prescribed in the Physician's Section on the previous page of this form under the terms listed below:

1. I understand and accept that occasional circumstances and activities occurring during the school day may make it impossible to administer the medication on the recommended schedule.
2. I will submit a new request form each time there is a change in the recommended dosage or time of administration, and at the beginning of each school year.
3. I understand that medication not collected by me within thirty (30) days of the date of the last dosage to be administered (as designated by the physician) shall be discarded.
4. I will deliver the medication in the original, labeled container from the doctor or pharmacist or assume responsibility for safe transport of the medication by my child.
5. I will monitor my child's school supply of medication and be responsible for providing additional medication as needed.
6. 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 or indirectly from this authorization.

Parent/Guardian Signature_____________________________________ Date______________

Parent/Guardian Name (print)____

Address____

Home Phone____

Work Phone____

SEE PREVIOUS PAGE FOR PHYSICIAN SECTION