MIDDLETOWN CHRISTIAN SCHOOLS

Permit for Administering Prescription Medication
(in accordance with Ohio Revised Code 3313.713)

The use of medication during school hours is discouraged. Use this form if it is essential for a student to receive medication during the school day.

This section is to be completed by the parent or guardian.

Name of Student: ____________________ Birthdate: ____________
Student's Address: ______________________________
School: ________________ Grade: ______ Home Room: ________

I request school personnel to administer the medication as instructed and agree to notify the school if I change physicians or if the medication is changed or eliminated. I will deliver the medication to the school in the original container and understand the **medications are not to be transported by my child.** I understand that it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility for the results of such medication.

Parent/Guardian Signature: ____________________ Date: ____________
Telephone during school hours: ______________ Other telephone: __________

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN

Complete reverse side if student is to carry and self-administer asthma inhaler.

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 Telephone: __________
Special Instructions:
Administration: ______________________________
Storage: ______________________________
Other: ______________________________

Manual Signature Required (NO STAMPS)

Prescribing Physician (print): ______________ Signature: ______________
Physician's Address: ______________________________

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: ____________