Pickerington SCHOOLS
EDUCATING FOR TOMORROW

REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL GRADES K-12

PHYSICIAN'S SECTION

Name of student:

_____ is under my care and should receive the following:

Name of Drug:	Dosage:	Route:
Time of day to administer:	Diagnosis/reason for medication:	Special storage instructions:
Specific instructions for administration:	Possible side effects to watch for:	
Start date for medications:	Expiration date of this request:	

FOR ASTHMA INHALERS:

Student has been instructed on proper use of inhaler and is responsible to carry inhaler and self-administer:

☐ **YES** ☐ **NO**

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

_____

_____

List any severe reactions that may occur to another student for whom the inhaler is not prescribed should he/she receive a dose of this medication: _____

_____

We request a duplicate inhaler be provided for availability in the clinic.

Physician's Signature	Date	Telephone

PARENT'S SECTION

I hereby request and give my permission to the Board approved personnel to administer the above stated medication to my child. I further acknowledge by signing this form that the school district or its personnel are under no obligation to render assistance in administering medication and do hereby release all Board designated school employees and the Board of Education from liability for damages or injury resulting from either performing or not performing the assistance requested.

I have read and understand the policy for administration of medication.

Name of Student:	Date of Birth:	School Building:	Homeroom Teacher:
Home Address		Phone:	

A new Request for Administration of Medication form is required each school year.

Signature of Parent/Guardian	Date