WEST GEAUGA LOCAL SCHOOL DISTRICT
AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL

West Geauga School Board has adopted a policy in adherence with the Ohio Revised Code for administration of medication at school. The form below must be completed and provided to the school for administration of prescription and over-the-counter medications. The parent/guardian must provide the medication in the original container. The form is only valid for the current school year.

If it is an emergency medication the student is to carry, the student also needs to sign the form.

At the high school level, students with medications at school are responsible for notifying their teacher if the medication needs to be available on field trips.

PHYSICIAN / DENTIST ORDER: **Do not leave any item blank**

Student Name: ____ DOB____________

Medication: ____ Dose: __________________ Route: ________

Frequency/Time: _____________________________________ start date: ____________ stop date: __________

When to be administered, if "as needed": ____

Instructions and/or Restrictions: ____

Side Effects / Adverse Reactions: ____

Procedure to follow in the event medication does not produce the expected relief: ________________________

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Special Storage Requirement: ______________________________ Additional Information attached: yes no

For Emergency Medications Only (mark yes or no):

This student is both capable and responsible for carrying and self-administering the above medication: yes no

Physician Name: ______________________ Signature: _______________________ date: __________

Address: ____ Phone: _______________________

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PARENT/GUARDIAN CONSENT:

I request the medication above be administered, as ordered by the physician, to my child. I agree to abide by the school policy. I agree to notify the school in writing, including a physician order, should there be a change in the child's medication.

Date: ______________ Signature: ____________________________ Relationship to Student: _______________

Phone numbers during school/activity hours if you need contacted: _______________________ __________________

Student home address: ____

STUDENT AGREEMENT:

Self-Administration

I accept responsibility for self-administering the above medication. I will not share the medication with others; I will keep the medication secured; I will tell a teacher if I need to use the medication and inform them if I do not obtain relief following it's use.

High School students

I will inform the nurse in advance if the medication needs to be with the teacher on a specific field trip.

Date: ______________ Signature: ____________________________

Date: _______ School Nurse Signature: ____________________ Building Principal Signature: ____________________

FAX NUMBERS: H.S. 440-729-5959 M.S. 729-5909 Lindsey 729-5989 Westwood 729-5924