

Sandusky City Schools



Prescriber's Request for the Administration of Medication in School

(Prescriber's order for medication in accord with 3313.713 and 3313.716 of the Ohio Revised Code)

Student's Name _____ Date _____

Student's Address _____ City _____ Zip _____ - _____ - _____ Phone _____ - _____ - _____

School Building _____ Grade _____

Medication	Route	Dose	Time of Administration
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Starting date of this request _____ Termination date for medication _____

Special instructions (if any) _____

MEDICATION WILL BE ADMINISTERED BY SCHOOL PERSONNEL (unless otherwise stated).

Adverse reactions that should be reported to the prescriber: _____

Adverse reactions school personnel should look for in an unauthorized user: _____

Prescriber Signature _____ Date _____ Emergency phone number(s) where prescriber can be reached _____

FOR ASTHMATICS ONLY

STUDENT IS ALLOWED TO CARRY THEIR INHALER AND SELF ADMINISTER PER PRESCRIBER'S ORDER: YES [] NO []

In the event the asthma medication does not produce the expected relief, please do the following: _____

If the inhaler malfunctions, please do the following: _____

Parent/Guardian Request for the Administration of Medication in School

I request the school staff to administer the medicine to my child as ordered above by the attending prescriber. I will submit to the school a revised "Request" form signed by the prescriber and myself if there is any change in the above orders. I understand that I am required by Ohio law to provide the school with the medication in the original container as dispensed by the prescriber or pharmacist.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Address _____

Home Phone # _____ - _____ - _____ Work Phone # _____ - _____ - _____ Cell Phone# _____ - _____ - _____

Reminder to Parents/Guardian:

Medication must be provided to school in original container dispensed by the prescriber or pharmacist.
Please ask prescriber or pharmacist for one extra labeled container for school.

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MEDICATION LOG

Student _____ School _____ Date Started _____ School Year _____

Medication _____ Strength _____ Dose _____ Time _____

Special Instructions _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	29	30	31
August																														
September																														
October																														
November																														
December																														
January																														
February																														
March																														
April																														
May																														
June																														

Initials/Signature: _____

KEY

- Initials = Medication taken within 1 hour of designated time
- O = No medication available
- X = No school
- AB = Absent
- ER = Error

COMMENTS