LOGAN ELM LOCAL SCHOOL DISTRICT
9511 Tarlton Road Circleville, OH 43113
Grades **PK-5** Nurse **Phone: 740-477-4460 / FAX: 740-477-1324**
Grades **6-12** Nurse **Phone: 740-477-4430 / FAX: 740-477-3592**
Email: nurse@loganelm.org

MEDICATION AUTHORIZATION FORM

Parent Request for Administration of Medication
By School Personnel
As required by Section 3313.713 Ohio Revised Code

STUDENT NAME _____ **DATE OF BIRTH** _____

SCHOOL BUILDING _____ **GRADE** _____ **TEACHER** _____

PARENT/GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. Both the parent (top section) AND the licensed prescriber (bottom section) must complete this form.

2. Medication must be provided in the student's labeled prescription bottle. The prescription label must match the instructions from the prescriber. If it is a non-prescription or over-the-counter medication, it must be in the original container.

3. New forms must be submitted each school year AND for each new medication. New forms must also be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.)

I hereby request and give my permission to the Board-approved personnel to administer this stated medication to my child. I further acknowledge by signing this form that I 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 also authorize the exchange of information between the health care provider and the school regarding this medication order, when deemed necessary by school personnel.

_____ _____
Signature of parent/guardian Date

PHYSICIAN

Please Print

_____ _____
MEDICATION NAME & DOSAGE **TIME MEDICATION IS TO BE GIVEN**

_____ _____ _____
DIAGNOSIS **START DATE** **END DATE**

POSSIBLE SIDE EFFECTS TO WATCH FOR _____

_____ _____
PRINTED NAME OF LICENSED PRESCRIBER **PHONE**

_____ _____
OFFICE ADDRESS **FAX**

_____ _____
*** SIGNATURE OF PHYSICIAN for MEDICATION ORDER** **DATE**