St. Paul the Apostle Catholic School
61 Moss Road
Westerville, Ohio 43082
Phone: 614-882-2710

REQUEST TO ADMINISTER MEDICATION TO A STUDENT DURING SCHOOL HOURS

As Required By Section 3313.713 Ohio Revised Code

Student Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____

PARENT SECTION

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

1. This form must be completed by both the parent (top section) and the prescribing physician (bottom section)
2. Medication must be kept in the student's prescription labeled bottle. (Pharmacy may provide an extra bottle for long-term medication.) Prescription label must match instruction from doctor. If it is a non-prescription drug, it must be in the original container.
3. The school will accept a one (1) week's supply of medication at one time for five (5) school days.
4. A revised statement signed by the physician and parent/guardian must be provided when there is a change in the dosage to be given and a new form will be provided each school year.
5. This statement will release and hold school personnel harmless from any and all liability for damages or injury resulting directly or indirectly from the presence of the medication in the school or its use by the student.

When possible, give medication outside of school hours. For example, to be able to administer four (4) doses to the child, it might be given before school, immediately after school, before child's bedtime and before parents' bedtime. Please contact the school nurse if you have questions.

Signature of parent: _____ Date _____

Parent phone number: _____ _____
Day time *Evening*

PHYSICIAN SECTION – *TO BE COMPLETED BY THE PHYSICIAN ONLY!*

St. Paul School urges you to schedule the times of taking medications by students outside school hours. When that is not possible, receiving or using medications will be permitted during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by: _____
Name of Student

FOR DAILY MEDICATIONS

DRUG	DOSE	ROUTE	TIME TO BE GIVEN

FOR AS NEEDED MEDICATION

DRUG	DOSE	ROUTE	TIME TO BE GIVEN

Diagnosis for which medication is prescribed?	
Any severe adverse reactions that should be reported to the prescriber *?	
Special instructions for administration, including sterile conditions and storage?	
Start date to administer at school:	Expiration date:

Physician's signature: _____ Date: _____

Physician's printed name: _____ Phone: _____