FAIRFIELD CITY SCHOOL DISTRICT JHCD-E
HEALTH SERVICES DEPARTMENT

SCHOOL MEDICATION PERMIT
(IN ACCORDANCE WITH OHIO REVISED CODE 3313.713)

The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This section to be completed by the parent or guardian

Name of Student_____Birthdate_____

Students Address_____

School_____Grade_____Home Room_____

I request school personnel administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand that if the physician orders an asthma inhaler for self-administration that I should provide a second inhaler to be stored in the student clinic (in the event the student forgets his/hers) and that the student should report use of the inhaler to the nurse for assessment of effectiveness. I agree to hold Fairfield City School District and its employees free from all responsibility for the results of such medication.

Parent/Guardian Signature_____Date_____

Phone during school hours_____Other telephone_____

This section to be completed by the physician

Medication_____Date of authorization_____

Dosage_____Time(s) to be given:_____

Date to begin_____Date to end_____

Adverse reactions to be reported_____

Special Instructions – Administration:_____Storage:_____

Other:_____

If the student is to carry an asthma inhaler for self-administration, complete this section:

Procedure to follow if asthma symptoms are not relieved:_____

Adverse reaction if used by unauthorized person:_____

The student has been instructed in the proper use of the inhaler, the expected results and possible side effects, and is capable of carrying and self-administering the medication.

Name of Physician (print): _____

Physician's signature:_____

Physician's address_____

Physician emergency phone:_____Other phone:_____