MCS-202
Rev. 2/2008

MASON CITY SCHOOLS

Dispensing Medication at School

(In accordance with Ohio Revised Code 3313.713, 3313.716 and 3313.718)

It is recognized that some students must take medication during school hours. *Parents/Guardians/Residential facility personnel are encouraged to administer medication before and after school whenever possible.* If this is not possible, school personnel will provide necessary assistance; however, Mason Board of Education policy requires written consent of **both** the physician and a parent or guardian (or residential facility representative with consent to act on behalf of the parent or guardian) before medication can be given to a student by school personnel. The following information is necessary in order to comply with this policy.

Return the completed form to the Health Services Coordinator in your child's building.

Name				DOB	
Address				Telephone #	
School		Grade		Teacher/Team/ID#	

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

Name of Medication			
Dosage			
Frequency and Route			
Student to Carry Medication?	Yes ☐ No ☐ (Applies to Emergency Medications only - EpiPens, inhalers or other specific emergency treatment identified by physician)		
Student to Self- Administer Med.?	Yes ☐ No ☐ ("Yes" indicates student has been instructed in proper use, expected results and possible side effects of medication)		
Date to Begin Administration			
Date to Terminate Administration			
Possible Side Effects			
Physician			
Physician Telephone #		Physician Emergency Phone #	
Special Storage Instructions:			
Physician's Signature			

The medicine must be in oral, topical, rectal, inhalation or subcutaneous/intramuscular injectable form. It must be in a clearly marked container from the pharmacist. The label must show the child's name, the dosage directions, the doctor's name, and the prescription number. Identification of the potential for interaction with other medications taken by this student is the responsibility of the prescribing physician.

TO BE COMPLETED BY PARENT/GUARDIAN OR RESIDENTIAL FACILITY REPRESENTATIVE WITH CONSENT TO ACT ON BEHALF OF PARENT OR GUARDIAN

Pharmacy		Telephone #	

The undersigned agree not to file or make any claim against anyone for negligence in connection with the administration or non-administration of any medicines and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.

I give my permission for the principal or his/her designee to administer the prescribed medication.

Signature		Date	

THIS PERMISSION IS NO LONGER VALID AT THE END OF THE CURRENT SCHOOL YEAR