



Cincinnati Public Schools

Administration of Medication Form

Parent/Physician Request for School Personnel to Administer Medicine

Cincinnati Board of Education policy (Students Section, 5141.3) requires consent of parent, guardian, or eligible student 18 years or older before medication (including prescription, over the counter, inhalers, Epinephrine, etc.) can be given to a child by school personnel. The following information is necessary in order to comply with this policy. Please return this completed form to your child's principal. **Please answer all questions.**

Name of Student: _____
Date of Birth: _____ Home Telephone No.: _____
Address: _____ Zip: _____
Primary Emergency Phone No.: _____
Secondary Emergency Phone No.: _____
School: _____ Grade: _____
School Fax Number: _____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN (If not applicable, indicate N/A)

Name of Medication: _____
Dosage: _____
Frequency: _____
How Administered: _____
Date to Begin Administration of Medication: _____
Date to Terminate Administration of Medication: _____

Possible side effects that should be reported to the physician:

Possible side effects to another student whom the medication is **NOT** prescribed who receives a dose:

Special conditions for storage of drug: _____

*Procedures to be followed if asthma medication does not alleviate child's asthma attack (Use back of form if necessary or complete Asthma Emergency Form): _____

**Procedures for school employees if the student is unable to administer the Epinephrine Auto-injector medication or if it does not produce the expected relief: _____

____ Yes ____ No As a prescriber, I have determined that this student is capable of possessing and using this auto-injector appropriately and have provided the student with training in the proper use of the auto-injector.

Physician's Signature: _____

Physician's Name _____

Physician's Emergency Telephone No.: _____

Please complete other side

TO BE COMPLETED BY THE CHILD'S PARENT OR ELIGIBLE STUDENT

The medicine must be in pill, capsule or spoon form, or an auto-injector or an asthma inhaler and must be clearly marked from the pharmacist. The label must show the child's name, the dosage directions, the doctor's name, and the prescription number.

This permission is no longer valid at the end of the current school year or if there are any changes ordered to this form in the following:

- 1. Name of the medication**
- 2. Dosage**
- 3. Recommended time of dosage**

Pharmacy: _____

Telephone No.: _____

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

____ As the parent/guardian of this student or eligible student, I give my permission for the principal or designee to administer the prescribed medication.

For Students with Asthma*

____ As the parent/guardian of this student or eligible student, I authorize my child or myself to possess and use the asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

For Students with EpiPen/Twinject**

____ As the parent/guardian of this student or eligible student, I authorize my child or myself to possess and use an Epinephrine Auto-injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. **I will provide a backup dose of the medication to the school as required by law.**

Name of Parent/Guardian/Eligible Student (please print):

Signature of Parent/Guardian/Eligible Student: _____

Date: _____

Additional Information:

Please complete other side