

Heritage Christian School

LICENSED PRESCRIBER'S ORDER FOR PRESCRIBED ORAL MEDICATION

Both State Law O.R.C. and all public schools within Stark County require the following information when children need administration of prescription drugs. Please complete the following information and forward to the school.

1. Name of Student: _____ Age: _____
Last Name First Name Middle Initial

2. Address: _____
House Number Street Name Town/City Zip

3. School District: _____ Class/Grade: _____

4. Name of Medication: _____ Oral Dosage: _____

5. Times at which the medication is to be administered: _____

6. Administration of medication to begin: _____

7. Administration of medication to end: _____

8. Significant side effects (adverse reactions) which should be reported to the licensed prescriber: _____

9. Special instructions for administration of drug, including sterile conditions and storage: _____

Licensed Prescriber's Signature

Emergency Phone Number

Parent/Guardian Signature

Parent/Guardian Phone Number

Note: There must be notification to school employees if any information provided by the licensed prescriber changes. The medication must be delivered to the school by the parent/guardian in the container in which it was dispensed by the licensed prescriber or licensed pharmacist.

THIS FORM HAS BEEN APPROVED BY THE STARK COUNTY MEDICAL SOCIETY

Date: _____

PRESCRIBED MEDICATION AUTHORIZATION

To Parent or Guardian:

To comply with your request to administer the medication to your child as prescribed by his/her licensed prescriber, you must agree to the following:

1. Your written permission must be on file at your child's school.
2. You are responsible for the safe delivery of the medication in the container from the pharmacy to the school.
3. You agree to notify the school immediately if there is a change in the use of the medication.
4. You understand that we must have written directions from the licensed prescriber.
5. Liquid medication shall be the responsibility of the parent and will be administered only at the principal's direction.
6. You release the Board of Education and its employees from any and all liability for damages or injury resulting directly or indirectly from this authorization.
7. You also give permission to school personnel to contact the licensed prescriber with questions regarding the medication order and to send progress reports to clarify information.

PARENT'S AUTHORIZATION TO GIVE MEDICATION

School Heritage Christian School Homeroom _____

I have read and understand the above agreement. I hereby request and give my permission for a

Heritage School staff member to administer _____ of _____
(# Of tablets) (Name of Drug)

at _____ as prescribed by licensed prescriber _____
(Time) (Name of Prescriber)

To my child, _____ Childs birthdate: _____
(Childs Name)

Parent/Guardian's Signature: _____ Date: _____

Address _____ Home Phone _____

_____ Work Phone _____

Cell Phone _____