Bellbrook - Sugarcreek School District

Authorization for Administration of Prescription or Over-the-Counter Medication by School Personnel

Part I – To be completed by Parent/Guardian

Student name _____ Date of Birth _____

School _____ Grade _____ Teacher _____

Please review the following steps required for permission of school personnel to administer any prescription and/or over-the-counter medication to your child and sign this section:

1. Both parent (top section of form) and the physician/prescriber (bottom section of form) must complete form.
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication). The prescription label must match the instructions from the physician (as listed below). If it is a non-prescription medication, it must be in the ***original*** container.
3. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (example – changes in dose, time, etc.).

I request that medication be administered to my son/daughter according to the directions of the physician as listed in ***Part II*** of this form (see below). I also authorize the exchange of information between the health care provider and the school (when deemed necessary by the school nurse) regarding this medication order.

→ **Signature of Parent/Guardian _____ Date _____**

Home Phone # _____ Business Phone # _____ Cell Phone # _____

Part II – To be completed by Physician/Licensed Prescriber

I verify that this medication must be taken by (name): _____

Diagnosis for which medication is prescribed: _____

Medication/Procedure: _____ Strength: _____ Dose: _____

Time(s) medication is to be taken: _____

Administration start date: _____ End date: _____ Expiration date of medication: _____

Instructions or precautions, including possible side effects: _____

_____

→ **Physician's/Licensed Prescriber's signature _____ Date _____**

Physician's/Licensed Prescriber's printed name _____ Phone # _____ Fax # _____