Dear Parent/Guardian,

In order to administer ANY medications (both prescription and over the counter, including cough drops, eye drops and non prescription medications) to our students during school hours; the following steps must be taken:

- The attached form must be completed and signed by your child's healthcare provider AND the parent/guardian.
- All medications must be brought to the health clinic by a parent or guardian.
- Medications must not be expired and must be in the original container.
- Prescription medications must be in the original container with the student's name, medication name and dosage and date. *(If you only have one prescription bottle that you keep at home, you may ask your pharmacy for a second labeled container to provide to the school)*
- Medications provided MUST match the order from the provider.
- Supplies must be labeled with your child's name and will be kept in a secure location in the health clinic.
- Parent/Guardian will notify the health clinic staff if the order changes or is discontinued (A new Order Sheet is required for any changes)
- All medications must be picked up at the end of the school year, or they will be destroyed.

Please contact the school health clinic with any questions.

Thank you,

BEDFORD CITY SCHOOL DISTRICT

PROUDLY SERVING BEDFORD • BEDFORD HTS. • WALTON HILLS • OAKWOOD

AUTHORIZATION TO ADMINISTER MEDICATION

Student Name:_______________________________________ Date of Birth: _______ Grade: ____ Teacher:___________ School: ____________________

THIS SECTION IS **TO BE COMPLETED BY THE HEALTH CARE PROVIDER** *Please print clearly and complete **ALL** sections.*

NAME OF MEDICATION	STRENGTH	DOSE	ROUTE (circle or highlight route)	FREQUENCY (include time of administration for daily medication and include minimum time interval for prn dosing)	DIAGNOSIS	START DATE	STOP DATE
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	___________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	___________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	___________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR

Precautions and/or adverse reactions to report____

Date: _____ Health Care Provider Signature: ________________________________ Health Care Provider Name ___________________________

Address____ Phone Number: ____________________ Fax Number: ____________________

TO BE COMPLETED BY PARENT OR GUARDIAN: I give my permission for (Name of child)_____________________________) to receive the medications listed above at school or during school events according to the school policy. The school nurse (or other school personnel) involved with the supervision of my child's health, has my permission to exchange health information with the health care provider. For the safety of my child and all other children I have read and agree to adhere to the school policy regarding medications at school. I understand that the school district and any of its personnel are absolved from any civil liability, which might be associated with the medication assistance.

Parent/Guardian Signature: ____________________________ Parent/Guardian Name: ____________________ Date: ___________

Parent/Guardian Phone Numbers: Cell _________________ Home_______________Work______________ Other ___________

Please note: *Medication must be delivered to school by a parent or guardian in the container in which it was dispensed by the prescribing health care provider, licensed pharmacist or pharmacy. If the medication or dosage is changed, a new form must be completed.* ***THIS FORM MUST BE COMPLETED EVERY SCHOOL YEAR.***

TO BE COMPLETED BY SCHOOL: Date received at school: ________ School Nurse Signature:______________________