Akron Children's Hospital
School Health Services

Attach Student Picture If available

Prescription Medication Administered at School

School: _____

School Year: _____

Student Name:_____ D.O.B.: _____

Student Address: _____

Class/Grade: _____

To Be Completed by Doctor:

Name of medication: _____ Dose: _____

Time to be given: _____ (during school hours)

Reason for medication: _____

Form of medication: ___ Tablet ___Liquid ___Inhaler ___Nebulizer ___Other

Start Date: _____ Stop Date: _____

Special Instructions: _____

Potential adverse reactions to be reported: _____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____ **Phone:** _____
Printed Name

Fax: _____

To Be Completed by Parent/Guardian:

I give permission for my child to receive medication at school according to the school district policy and as instructed by the physician and agree to:

- Assume responsibility for safe delivery of the medication in its original container to the school
- Notify the school immediately if there is any change in the use of this medication
- Have a new form completed by the doctor if medication or dosage is changed
- Notify the school of changes in health care provider
- Allow School Health Services staff to send and/or receive information related to my child's health, as they deem appropriate for the duration of this order as noted above

I hereby release from liability, and in addition agree to indemnify, all school employees, the Board of Education and School Health Services for damages or injury resulting from the use, misuse or nonuse of such medication except as such Board, School Health Services or its employees are grossly negligent or engage in wanton or reckless misconduct.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____

Alternate phone number in case of emergency: _____

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR