

ANTWERP LOCAL SCHOOLS

Antwerp, Ohio

**PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A PRESCRIBED
MEDICATION/DRUG OR TREATMENT**

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE
PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES
MUST BE COMPLETED.

Name of Student

Address

Antwerp Local Schools
School

Grade/Homeroom

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an
authorized staff member

in accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The
medication/drug must be received by the District (i.e., the person authorized to
administer the drug to the student) in the container in which it was dispensed by the
prescriber or a licensed pharmacist.)

C. I will notify the school immediately if there is any change in the use of the
medication/drug or the prescribed treatment. (You must submit to the District a
revised licensed prescriber's statement, signed by the prescriber, if any of the
information contained in the statement changes.)

D. I release and agree to hold the Board of Education, its officials, and its employees
harmless from any and all liability foreseeable or unforeseeable for damages or injury
resulting directly or indirectly from this authorization.

Signature of Parent *

Date

Home Telephone

Work Telephone

* Parent, guardian, or other person having care or charge of the student.

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

Name of Student

Address

School

Grade/Homeroom

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student (specify the name of the drug-one per form)

Date the administration of the drug is to begin:

Date the administration of the drug is to cease:

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered: _____

Specify any special instructions for administration of the drug, include sterile conditions and storage: _____

Report the following side effects (i.e., severe adverse reactions) to my office immediately:

Prescriber's Signature _____ Telephone: _____

Printed/Typed Name _____ Date: _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

Principal