**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 STATEMNET

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

_____Antwerp Local Schools_____ _____
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, and include sterile conditions and storage:

_____
_____
_____

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

_____
_____
_____

_____ _____
Prescriber's Signature Telephone

_____ _____
Printed Name Date

## AUTHORIZATION FOR STAFF

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

_____
_____

Principal _____