LICKING VALLEY LOCAL SCHOOL DISTRICT
1379 LICKING VALLEY ROAD N.E.
NEWARK, OH 43055

PRESCRIBED MEDICATION
AUTHORIZATION TO ADMINISTER OR ASSIST WITH MEDICATION OR TREATMENT

Scheduling of medication or treatment outside of school hours is encouraged. When that is not possible, this form must be completed every school year prior to school personnel dispensing medication or treatment. The **MEDICATION AND THIS FORM** is to be taken to the building principal and kept on file in the school office.

A. Physician Section

Student's Name ____ Date of Birth______________________

Student's Address ____

Prescribed Medication/Treatment ____

Dosage, Time and Route ____

Side Effects or Adverse Reactions to be Reported to Parent or Physician___________________________

____

Instructions for Administration Including Storage and Sterile Requirements ________________________

____

Beginning Date ____________________________ Ending Date _____________________________

Physician's Printed/Typed Name____

Physician's Address ____ Phone ___________________

Physician's Signature____

B. Parent/Guardian Section

As parent/guardian of the above named child, my signature below authorizes the Principal, Nurse, or other responsible school personnel to administer or assist with medication or treatment to my child as instructed in **Part A** by the physician. I do assume responsibility for:

A. Safe delivery of medication in the **ORIGINAL DRUGSTORE CONTAINER** to the school office.

B. Instructing my child to present himself/herself and to take the medication at the scheduled time.

C. Understanding the medication will be destroyed at the end of this school year if not collected by parent/guardian, or if the prescription ends.

D. I will notify the school immediately if there is any change in the use of the medication of the prescribed treatment.

E. 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.

Parent/Guardian Signature __________________________________ Date________________________

Home Phone __________________________________ Work Phone ______________________________

LICKING VALLEY LOCAL SCHOOL DISTRICT
1379 LICKING VALLEY ROAD N.E.
NEWARK, OH 43055

NONPRESCRIBED (Over-the-Counter) MEDICATION AUTHORIZATION TO ADMINISTER OR ASSIST WITH MEDICATION OR TREATMENT

Scheduling of medication or treatment outside of school hours is encouraged. When that is not possible, this form must be completed every school year prior to school personnel dispensing medication or treatment. The **MEDICATION AND THIS FORM** is to be taken to the building principal and kept on file in the school office.

***To be Completed by Parent/Guardian**

Student's Name ____ Date of Birth______________

Student's Address ____

Name of Drug ______________________________________ Dosage _____________________

Route ______________________ Time____

As parent/guardian of the above named child, my signature below authorizes the Principal, Nurse, or other responsible school personnel to administer, or assist with the medication or treatment to my child. I do assume responsibility for:

A. Safe delivery of medication in the **ORIGINAL DRUGSTORE CONTAINER** to the school office.

B. Instructing my child to present himself/herself and to take the medication at the scheduled time.

C. Understanding the medication will be destroyed at the end of this school year if not collected by parent/guardian.

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.

Parent/Guardian Signature __________________________________ Date________________

Home Phone ______________________________ Work Phone __________________________