CIRCLEVILLE CITY SCHOOLS
PRESCRIPTION and/or OVER–THE COUNTER MEDICATION AUTHORIZATION FORM

NAME_____ **PHONE**_____

ADDRESS_____

BIRTHDATE_____ **SCHOOL**_____ **GRADE/ROOM**_____

To the Parent or Guardian: BOTH PORTIONS OF THIS FORM MUST BE COMPLETED. THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO RECEIVES OR USES **PRESCRIBED and/or OVER-THE COUNTER MEDICATION** IN SCHOOL:

1. I am requesting permission for the student named above to receive or use medication according to the doctor's verification on this form. I have instructed my child to report to the school office to receive the medication at the designated time(s).
2. I will keep an adequate supply of medication at school.
3. I will assume the responsibility for the safe delivery of the medication to the school office either by myself or call the principal to make other arrangements.
4. I will call the school office and send a written note if my child is taken off his/her medication. I will retrieve the medication within 3 days.
5. I will bring in a completed medication authorization form for any dosage/medication/doctor changes.
6. I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____

Signature of parent or guardian Date

Home Phone_____ Work Phone_____ Cell Phone/Pager_____

All medication must be in the original pharmacy dispensed/manufacturer's containers. Labels must match instructions from the physician on this form. A new form must be completed for each dosage/medication/physician change. Each school year a new form must be completed for EACH medication.

PHYSICIAN'S STATEMENT

To the Physician:
The Circleville Board of Education urges you to schedule the administration of medication to students at times outside school hours. When that is not possible, the administration of medications will be permitted, insofar as feasible, during the school day. Medication in pill form is preferable to liquids for use in school.

_____ _____

Medication **Dosage**

Form of medication: Tablet/Capsule, Nebulizer, Liquid, Other_____

Diagnosis for which the medication is prescribed_____

Medication to be taken at the following time(s)_____

Instructions/precautions (including possible side effects)_____

Adverse reactions that need to be reported to the physician_____

Prescription start date_____ Prescription ending date_____

Date form completed_____ Physician's Signature_____

Physician's printed name_____ Phone Number_____

Physician Address_____