CARROLLTON EXEMPTED VILLAGE SCHOOL DISTRICT
252 THIRD STREET N.E., CARROLLTON, OHIO 44615-1236

PERMISSION FOR THE DAILY CONSUMPTION OF PRESCRIPTION MEDICATION

I. **To Be Completed By the Physician**

To: CARROLLTON EXEMPTED VILLAGE SCHOOL DISTRICT PERSONNEL

The student listed has a medical need that requires the daily consumption (during school hours) of the prescribed medication below. It is requested that the school personnel administer the medication.

1. Name of Student______________________________ Date of Birth______________________

2. School______________________________________ Grade__________________________

3. Address____

4. Name of medication to be monitored:____

   Dosage:____________________________________ Time:____________________________

   Date to Begin:_______________________________ Date to End:______________________

   Purpose:____

5. Possible reactions that, if they occur, should be reported to physician:_____________________

   ____

6. Emergency steps to be followed in the event of the above occurrence: _____________________

   ____

7. ____ Phone Number: ___________________
   PHYSICIAN'S SIGNATURE

8. ____
   PHYSICIAN'S PRINTED NAME

IX. **To Be Completed by Parent or Guardian**

I (we) grant permission for ____
Student's Name

to daily consume____ at_____________________________
Medication Time of Day

We further request that the school personnel store in a locked cabinet, only a five-day supply, and administer the medication to the above student. Yes______ No______

I (we) have read and fully understand the attached procedure for the consumption of medication. I request that the drug prescribed by the physician be administered by principal or his/her designee. I agree to submit in writing a revised physician's statement in the event that any of the required information should change. I give permission for the principal or school nurse to contract the physician regarding the administration of this medication in the school setting. I agree to deliver a five day supply of medication weekly to the school in the proper container. I agree to pick up the medication within 3 days of termination of administration or at the end of the school year, or the school staff will dispose of the medication.

____Address__________________________________
Parent's/Guardian's Signature

Home Phone______________________ Work Phone________________Cell Phone________________

A copy of this form will be filed at the school nurse's office. DISTRIBUTION LIST FOR PROCEDURES FOR SCHOOL HEALTH SERVICES