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

REQUEST FOR ASSISTANCE IN THE ADMINISTRATION OF NON-PRESCRIBED MEDICATION

Some students are able to attend school only through the effective use of medication. If possible, all medication should be given under the supervision of parent/guardian outside of school hours. When this is not possible, school personnel may administer the non-prescribed medication. You must have this form filled out in full and the medication delivered to the school by the parent/guardian in the original labeled container in which it was dispensed. **Students who use medication on a daily basis, exceed dosage requirements, use the medication for a period exceeding that recommended on the labeling, indicate problems with this medication, or for whom this medication is not indicated will require documentation from a physician.**

FORM GOOD FOR ONLY ONE WEEK

INFORMATION FROM PARENT/GUARDIAN	
Student Name	School
Address	Teacher/Grade
Home Telephone	Parent/Guardian Work Tel.
Medical conditions and/or health concern:	
Other medications being taken	
Allergies	
The following medication needs to be administered during the school hours. I understand that unlicensed school personnel will be assisting the child with the self-administration of this medication. This medication has already been administered to this child and there has been no untoward reaction to the medication. School personnel are not liable for effects related to the use of this medication.	
Name of drug	
Dosage and route of administration	
The specific conditions for using this medication	
Physician Name **Address** **Telephone**	
I request that this medication be administered to the student. I give permission for the principal or school nurse to contact the physician regarding the administration of this medication in the school setting. I agree to deliver the needed medication to the school in the original labeled container. I agree to pick up medication within 3 days of discontinuation or end of the school year, or school staff will dispose of medication.	
Parent/Guardian name Address Telephone	**Parent Signature** **Date**

For School Use Only

Request Accepted _____ Request Denied _____
Reason for Denial:
Individual(s) authorized to administer medication:
Signature of Building Principal _____ Date _____