

**SCHOOL HEALTH SERVICES
ST. LAWRENCE SCHOOL**

MEDICATION PERMISSION FORM

Ohio State Law requires consent of parent or guardian before medication can be given to a child by school personnel.

Name of student: _____ Date of birth: _____ Grade/Room _____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN

Name of medication: _____

Dosage: _____

How administered: _____

Possible side effects: _____

Duration of this permission: _____

Physician: _____ Telephone Number: _____ FAX Number: _____

Physician's Signature: _____

The medication must be in pill, capsule, or liquid form. Medication must be in the original container (including over-the-counter medication). The pharmacy label must show the child's name, the dosage directions, the doctor's name, and the prescription number. Per Ohio State Law, students may carry and self-administer "rescue" asthma inhaler and/or Epipen, if parent permission is given below.

TO BE COMPLETED BY THE PARENT

Pharmacy: _____ Telephone Number: _____

As the parent/guardian of this student, I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines.

I give my permission for the principal or his/her designee to administer the prescribed medication.

Signature of parent/guardian _____ Date signed: _____

THIS PERMISSION IS NO LONGER VALID AT THE END OF THE CURRENT SCHOOL YEAR.

Please return this form to the child's principal.