

**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: \_\_\_\_\_

The undersigned agree not to file or make any claim against anyone for negligence in connection with the administration or non-administration of any medicines and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicine.

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

Signature of parent/guardian \_\_\_\_\_ Date signed: \_\_\_\_\_

I give my permission for my child to carry and self-administer "rescue" asthma inhaler/Epipen.

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**THIS PERMISSION IS NO LONGER VALID AT THE END OF THE CURRENT SCHOOL YEAR.**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