FREMONT CITY SCHOOLS
Medication Form
Fax Numbers:

Atkinson 419-334-6749	**Croghan 419-332-4314**	**Hayes 419-334-6761**
Lutz 419-334-5499	**Otis 419-334-6788**	**Stamm 419-334-6746**
Washington 419-665-2241	**FMS 419-334-5494**	**Fremont Ross 419-334-5450**

According to O.R.C. Section 3313.713, prescription medicine necessary to keep a student in school may be administered provided certain provisions are met. The Fremont City Board of Education concurs with the need to safeguard student health in the administration of medication through implementation of the following:

PROCEDURES FOR IN-SCHOOL MEDICATION

1. No medication, prescription or over-the-counter, will be dispensed to students without a physician's order.
2. Prescription medication must be in the original container explaining what the medication is, when and how much to administer. No medication, including inhalers, will be given that is improperly labeled or in the wrong container.
3. A record shall be kept of all students requiring medication during school hours. This shall include date, name of medication, time, and signature of the person giving the medication.
4. Medication prescribed three times daily will not be given at school, unless specifically requested by the physician.
5. All students are to be responsible for their own inhalers subsequent to approval by the school nurse.
6. Designated school employee.

BUILDING LEVEL PROCEDURES

ELEMENTARY/MIDDLE SCHOOL: Any student on prescribed medication shall present the medication to the school office with the completed Parental Authorization Form. A licensed nurse or designated school employee will dispense the medications once daily.

ROSS HIGH: All students on prescribed medication shall present the medication and completed Parental Authorization Form to the school nurse. The nurse will register the medication and give the student a written permit. The student will be free to take the medication at designated times after it is registered.

PARENTAL AUTHORIZATION

I hereby request that the school nurse or designated school employee administer a prescription medication or procedure as instructed by the physician. I understand that I am responsible for: 1) delivering the medication to school and 2) notifying the school of any change of physician; notifying the school if the medication, the dosage, or the procedure is changed or to be eliminated.

I release and agree to hold the Board of Education, its officials, and it employees harmless from any and all liability foreseeable or unforeseen for damages or injury resulting directly or indirectly from this authorization.

Student Name:_____ School:_____ Grade:_____

Address:_____ D.O.B._____

Date:_____

_____
Parent/Guardian Signature

(This section to be completed by the physician)

____New Medication ____Revisions Date start:_____ Date cease:_____

Name of Drug:_____ Dosage:_____

Time of Administration:_____ Route of Administration:_____

Special Instructions: (storage, sterile conditions, etc.)_____

_____

_____

Adverse reactions/side effects to be reported:_____

_____

_____

_____ _____
Physician's Signature Date

_____ _____
Physician's Printed Name Telephone

NOTE: Medication must be sent in the original, properly labeled container with student's name, contents, dosage, and schedule.
School Nurse Verification