West Clermont Local School District
Authorization for the Administration of Prescription and Non-Prescription Medications, Herbs and Supplements by School Personnel

As required by Section 3313.713 Ohio Revised Code

Student Name	Address			
Date of Birth	Phone	School	Grade	Teacher

PARENT/GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child.

1. **Both** the parent and the physician must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. If it is a non-prescription medication, it must be received in the original container. The prescription label must match the instructions from the physician.
3. All medication must be brought to the school by the child's parent/guardian. Students are NEVER to transport medication to school.
4. **New forms must be submitted each school year and for each new medication**.

In consideration for the West Clermont Local School District and its designated employees administering the prescribed medication to my/our son/daughter as I/we are unable to do so during school hours, I/we in behalf of ourselves and our heirs, administrators, executors, successors, assigns and our child do hereby fully and forever release, acquit and discharge the West Clermont Local School District Board of Education, the Board members individually and the employee(s) of said School District administering the prescribed medication from any and all liability, actions, causes of actions, claims and demands of whatever kind or nature that I/we may have in behalf of myself/ourselves and my/our named child on account of any and all injuries, losses and damages which my/our named child may sustain from the administration of the prescribed medication or any injury or damages that may result from my/our child's failure to take the prescribed medication as administered by an employee of the School District.

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Parent/Guardian _____Date _____Daytime Ph #_____

Received by _____ Date _____

LICENSED PRESCRIBER SECTION

Name of Medication	Strength	Dosage	Time

Beginning date	Ending date	Diagnosis for which medication is prescribed

Possible side effects or adverse reactions _____

Physician's printed name	Phone
Physician's signature/date	Address

This form must be completed and returned to the Health Office before any medication can be administered.

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