# BETHEL LOCAL SCHOOLS MEDICATION POLICY

In compliance with Ohio State Law, school personnel cannot administer any medication, **INCLUDING OVER THE COUNTER MEDICATIONS,** to students unless a medication permission form is on file in the clinic. If the medication is an over the counter medication a form must be filled out by the parent. A doctor's signature is not necessary. For prescription medications, forms must be filled out by the parent and the preScriber. These forms can be requested from the clinic by contacting the clinic aide or any of the secretaries.

Medication must be kept locked in the clinic and dispensed by the clinic aide. Students may not carry and/or self-administer without supervision, any medications, **including over the counter medications.** Ohio law makes an exception to the rule for epipens and inhalers.* Over the counter medications should be in the original package and labeled with the student's name. Prescription medications must be in the container in which the pharmacy dispensed it, with the prescription label giving the student's name, name of the medication, dosage, time and route of administration.

*Epipens and inhalers: If the parent and physician feel that the student needs to carry either of these, permission to do so is granted if the parent and physician fill out and sign the required forms. If the student has permission to carry an epipen, a back-up epipen must be provided to the principal or clinic aide.

The school is not responsible for adverse effect of medication administered at the request of the parent/guardian or for doses inadvertetly omitted.

Parents may come to the school to administer medication to their child at any time.

**PLEASE RETAIN THIS POLICY FOR FUTURE REFERENCE**

RETURNED THE COMPLETED MEDICATION REQUEST TO THE OFFICE.

# PARENT REQUEST AND AUTHORIZATION
# TO ADMINSTER PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

**The following information is necessary for any student to use all medications or to receive treatment in school ALL SPACES MUST BE COMPLETED**

Name of Student _____ Address _____

School _____ Grade _____

A. I am requesting that my child named above to: (check all that apply)
   - ❑ Use or receive prescription medication
   - ❑ Receive prescribed treatment
   - ❑ Self-administered prescribed medication(s) in my presence or that of an authorized staff member
   - ❑ Self-administer over the counter medication(s) in my presence or that of an authorized staff member.

   in accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)
C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescrigbed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)
D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent* _____ Date _____

Primary Telephone _____ Work Telephone _____

*Parent, guardian or other person having care or charge of the student.

Bethel Local Schools
Fax 845-0592
Attn: Clinic Aide

## Licensed Prescriber Statement

To the Prescriber:

The School District required that all of the following information be provided before it will administer medication or treatment to the student.

_____ Name of Student

_____ Address

_____ School

_____ Grade

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student (specify the name of the drug) _____

_____

_____

Date the administration of the drug is to begin _____

Date the administration of the drug to cease _____

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered _____

_____

_____

Specify any special instructions for administration of the drug, including sterile conditions and storage

_____

_____

_____

Report the following side effects (i.e., severe adverse reactions) to my office immediately _____

_____

_____

_____

_____

Prescriber's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

**AUTHORIZATION FOR STAFF**

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):
Principal, teacher, nurse, building secretary, others as designated by IEP and/or 504 plan. (Board policy 5330)

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