Authorization for the Administration of Medication by School Personnel
Fairbanks Local Schools
As required by Section 3313.713 Ohio Revised Code

Student Name ____________________________________________________________
Grade ________________________ Teacher ________________________ Date of Birth ______

PARENT/GUARDIAN SECTION
Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section.

1. The following information must be completed properly and signed before administration of medication is to begin.
2. Prescribed medication - need prescriber and parent/legal guardian to complete/sign form.
3. Over the counter medication - only the parent/legal guardian need to sign.
4. Medication must be provided in the original store container or student’s labeled prescription bottle. The prescription label must match the instructions from the prescriber.
5. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.).
6. Unless agreed upon by the Principal, all medication will be locked in one designated place.
7. Students/bus drivers are NOT TO TRANSPORT any medication, including over-the-counter, to school.

I request that the following:

_____ OTC medication be administered to the above-mentioned student according to my directions.
_____ Prescribed medication from the licensed prescriber in the following section be administered to the above-mentioned student.
_____ I also authorize the exchange of information, when deemed necessary, regarding the prescribed medication between the licensed prescriber and the following school staff checked.

(Check all that apply)
_____ Principal   _____ School Secretary    _____ Guidance Counselor    _____ Child’s Teacher   _____ Nurse

OTC medication to be taken: __________________________________________________ Dosage: _______ Frequency: __________
Reason __________________________________________________________

Parent/Guardian Signature ________________________________________________ Date ____________________________

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LICENSED PRESCRIBER SECTION
I verify that this medication must be taken by: ____________________________ Name of Student

Diagnosis for which medication is prescribed ____________________________

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<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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Administration start date ________________ Expiration date ________________

Instructions or precautions, including possible side effects:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________

Physician’s signature (only) __________________________________________ Date ________________

Physician’s printed name __________________________________________ Phone ________________

Revised 6-2-2009