

Blanchester Local School District
**Authorization for the Administration of Medication
by School Personnel**

As required by Section 3317.713 Ohio Revised Code

Putman Elementary (grades K-3)

Phone 937-783-2681 fax 937-783-2229

Blanchester Intermediate School (grades 4-5)

Phone 937-783-2040 fax 937-783-3477

Blanchester Middle School (grades 6-8)

Phone 937-783-3642 fax 937-783-3477

Blanchester High School (grades 9-12)

Phone 937-783-2461 fax 937-783-5666

Student Name: _____ Date of Birth: _____

Student Address: _____

School: Putman Intermediate School Middle School High School

Grade: _____ Teacher: _____

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. Both the parent (top section) and the licensed prescriber (bottom section) must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. This prescription must match the instruction from the prescriber. If it is a non-prescription medication, it must be in the original container.
3. 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).

I request that medication be administered to my son/daughter according to the directions of the licensed provider 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.

Signature of the parent: _____ Date: _____

LICENSED PRESCRIBER SECTION:

I verify that this medication must be taken by: (student's name): _____

Diagnosis for which medication is prescribed: _____

Medication: _____ Strength: _____

Dose: _____ Time to be given: _____

Start date: _____ Expiration date: _____

Instructions or precautions including side effects: _____

Licensed prescriber signature: _____ Date: _____

Licensed prescriber printed name: _____ Date: _____

Licensed prescriber phone number: _____

Please note-an additional form is necessary for the authorization of student possession and self-administration/use of an asthma inhaler and/or epi-pen.

August 2011

