PERRYSBURG EXEMPTED VILLAGE SCHOOL DISTRICT

MEDICATION IN SCHOOL

Before the student will be permitted to take medication during school hours or to use a self-administer medication and asthma inhaler, the following steps need to be followed.

1. All student prescribed medication requests need to be on a Perrysburg Schools form, and have a doctor's signature. Before any nonprescribed medication or treatment may be administered (over-the-counter medication), the Board shall require the prior written consent of the parent along with a waiver of any liability of the District for the administration of the medication Only medication that has to be given during school hours will be considered.

2. Parents need to complete the Parent Request Form.

3. A Physician will need to complete the Licensed Prescriber's Statement form for prescribed medication. (please fill out both sides for EpiPen/Twinject medications)

4. When both the Parent request and Licensed Prescriber forms are complete, please return them to the clinic.

5. No medication will be given without a review of the paperwork by the District School Nurse and building Principal.

6. Medication must be sent in its original prescription bottle with the student's name, and exact dosage. All medication must be kept in the clinic locked box. Self-administered inhalers and approved medication should be kept in an agreed location worked out between staff, the parent, and the student. Over-the-counter medication must be in its original container and may only be dispensed as the instructions allow.

7. Medication needs to be brought to the clinic by a parent or guardian.

8. Medication may not be sent to school in the student's lunch box, pocket, or other means on or about his/her person.

9. Student medication request forms need to be resubmitted each school year.

Parent Request and Authorization to Administer a Prescribed or Over-the-Counter Medication/Drug or Treatment

To the Parent:

The following information is necessary for any student to use prescribed or non-prescribed (over-the-counter) medications or to receive treatment in school. All spaces must be completed.

_____	_____
Name of Student	Address
_____	_____
School	Grade
_____	_____
Medication Name & Dosing Instructions	

A. 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, store or a licensed pharmacist.)

B. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed 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.)

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

D. The following medications are available in tablet form to be administered to students in grades 7-12 according to package dosage instructions with your permission by checking the appropriate box:

☐ Ibuprofen (generic for Advil/Motrin) ☐ Acetaminophen (generic for Tylenol)

_____	_____
Signature of Parent*	Date
_____	_____
Home Telephone/Mobile Telephone	Work Telephone

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

(Only for EpiPen / Auvi-Q medications)

Parent/Guardian (or student if eighteen (18) or over) must acknowledge one (1) of the following (please initial):

The principal or school nurse (if one has been assigned to the student's building) has been provided with a backup dose of the student's medication: Yes _____ No _____

Principal or school nurse must acknowledge one of the following (please initial):

I have received a backup dose of the student's medication: Yes _____ No _____

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer prescribed 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) _____

_____

_____

Is the drug to be self-administered? Yes _____ No _____

Prescriber must acknowledge one of the following (please initial); (Only for EpiPen / Auvi-Q medications/Inhaler)

The student is capable of possessing and using the autoinjector/inhaler: Yes _____ No _____

The student has been trained on the proper use of the autoinjector/inhaler: Yes _____ No ___

Date drug administration is to: Begin _____ End _____

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 _____

* For EpiPen/Twinjet medication, please complete Allergy Action Plan on back.