

Student's  
Photo  
Here

United Local School Health Services  
8143 State Route 9  
Hanoverton, OH 44423

Student Grade \_\_\_\_\_  
Bus Number \_\_\_\_\_

Nurse's Phone: 330-223-2829 Fax: 330-223-2363

**Prescription Medication Form**

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Emergency Telephone Contact: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Circumstances for Use: \_\_\_\_\_

Dosage and Frequency: \_\_\_\_\_

Date Administration is to Begin and End: \_\_\_\_\_

(Must be renewed each school year or with each change of orders per ORC 3313.713)

Adverse Reactions to be reported to the Prescriber: \_\_\_\_\_

(Per ORC 3317.716 and ORC 3313.718)

Student May Carry Emergency Inhaler/Epinephrine \_\_\_\_\_ or Must be kept in the clinic \_\_\_\_\_

(Notice to provider: Backup dose of Epinephrine must be kept in the clinic per ORC 3313.718 if student is permitted to self-carry)

Other Special Instructions: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber Name, Address and Phone Number: \_\_\_\_\_

**TO BE COMPLETED BY THE PARENT/GUARDIAN:**

I grant permission for the prescriber, pharmacist, and school nurse to communicate in regards to this order. I authorize designated personnel of the school to administer/supervise self-administration of the above named medication as instructed. I permit this medicine to accompany my child on field trips and be administered as needed by trained school personnel during these trips. Students may not carry any medicine. I agree to deliver the medication to the school in an unopened, labeled, original container, supply it as needed, and pick it up at the end of the school year (Per Board Policy JHCD).

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
PHONE #

**TO BE COMPLETED BY SCHOOL PERSONNEL:**

I hereby acknowledge reading this request to administer medication and understand its content as well as the content of the board policy.

\_\_\_\_\_  
PRINCIPAL SIGNATURE

\_\_\_\_\_  
SCHOOL NURSE SIGNATURE