

MIDDLETOWN CHRISTIAN SCHOOLS

**Permit for Administering Prescription Medication
(In accordance with Ohio Revised Code 3313.713)**

The use of medication during school hours is discouraged. Use this form if it is essential for a student to receive medication during the school day.

School year: _____

This section is to be completed by the parent or guardian.

Name of Student: _____ Birthdate: _____

Student's Address: _____

School: _____ Grade: _____ Homeroom: _____

I request school personnel to administer the medication as instructed and agree to notify the school if I change physicians or if the medication is changed or eliminated. I will deliver the medication to the school in the original container and understand the **medications are not to be transported by my child**. I understand that it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility in the administration or omission of such medication.

Parent/Guardian Signature: _____ Date: _____

Telephone during school hours: _____ Other telephone: _____

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN

Complete reverse side if student is to carry and self-administer EMERGENCY medication *only*

Medication: _____

Date of Authorization: _____ Dosage: _____

Time(s) to be Given: _____

Date to Begin: _____ Date to End: _____

Adverse Reactions to be Reported: _____

Physician Emergency Telephone: _____ Alternate Telephone: _____

Special Instructions:

Administration: _____

Storage: _____

Other: _____

Prescribing Physician (print): _____

Physician's Address: _____

Physician's Signature: _____

For School Use Only

The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature: _____ Date: _____

Signature: _____ Date: _____

Address: 3011 North Union Road, Franklin, OH 45005 Office: 513-423-4542 Fax: 513-261-6841

Permit is only valid until end of the current school year