Gahanna Jefferson Public Schools

160 South Hamilton Road • Gahanna, Ohio 43230 • (614) 471-7065

Re: PRESCRIPTION MEDICATION

(AND NON-PRESCRIPTION MEDICATION FOR ELEMENTARY STUDENTS)

Dear Parents,

We strongly urge that all medications be administered at home whenever possible. Please consult the prescribing physician, nurse practitioner or dentist to ascertain if the medication can be administered at times when your child is at home. We will only administer medication at school if the physician feels it is absolutely necessary.

Before the school will give your child prescribed medication that must be taken at school, State of Ohio law (Section 3313.713 O.R.C.) requires that:

1. The parent must complete and sign a parent permission form.
2. The licensed prescriber complete and sign the provider portion of the form. A note from the prescriber will not be accepted unless it contains all the information contained in State law (Section 3313.713 O.R.C.).
3. The completed and signed form must be returned to school BEFORE the medication can be administered at school. If the form is being faxed to the school, please ensure that the original form with actual parent and provider signatures is received by the school within one week of receipt of the faxed copy.
4. The medication must be brought to school, **by a parent or other responsible adult,** in the **original container** labeled with your child's name, the provider's name, the name of the medication, the dose and time it is to be taken. The instructions on the medication label must match the information given by the prescriber on the medication form.
5. Each medication must have a separate form.
6. *Any change in dosage will require new forms to be completed by the prescriber and parent before the new dosage can be given. A new prescription bottle with the correct label must be provided to the school.*
7. If liquid medications are prescribed, the parent must provide an accurate measuring spoon.
8. All medication must be kept in the clinic (except for asthma inhalers or auto-injector epinephrine, provided appropriate forms have been completed and student requirements met).

These policies are for the health and safety of your child. If you have any questions, please contact the principal or school nurse.

With kind regards,

School Nurse

PLEASE KEEP THIS PAGE!

Revised May 2007

Gahanna Jefferson Public Schools

160 South Hamilton Road • Gahanna, Ohio 43230 • (614) 471-7065

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN

Student name ____ Birth date _______________ Parent name__________________________________

Address____ Home phone ___________________ Work phone____________________

School____ Grade_________ Teacher (homeroom) ____________________________________

I AGREE TO THE FOLLOWING:

1. I am requesting permission for the student named above to take medication according to the prescriber's verification on this form.
2. I will assume responsibility for safe delivery of the medication to the school office either by myself or by a responsible adult and for keeping record of the amount of medication at school so I can replenish the medication when needed.
3. I will deliver medication only in its original pharmaceutical containers.
4. I will notify the school immediately if there is any change in the directions for use of the medication and will have a new authorization form completed for any changes.
5. I understand that any medication left in the building after the last day of school will be discarded.

I hereby release the Gahanna-Jefferson Public School District Board of Education, its officials and employees, from any and all liabilities for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested.

_______________________________________ ____________________ ______________________

Signature of Parent/Guardian Relationship Date

TO BE COMPLETED BY THE LICENSED PRESCRIBER

The above-named student is under my care and should receive the following:

_______________________________________ ____________________ ____________________ ____________________

Medication Dosage Route Time

Reason for medication:____

Specific instructions for administration, including storage, sterility requirements and probable side effects:_____________

____

Possible reactions that should be reported to the provider:____

Beginning date of this request:_________________________________ Expiration date:_______________________________

_______________________________________ ______________________

Signature of licensed prescriber Date

Printed name of licensed prescriber____

Address____ Phone___________________ Fax_______________________

FOR SCHOOL USE ONLY

_______________________________________ ______________________

Signature of school nurse Date

Form 5330 F1
revised 4/04