## PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

**THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.**

| ______________________________ | ______________________________ |
|---|---|
| Name of Student | Address |
| ______________________________ | ______________________________ |
| School | Grade |

A. I am requesting permission for my child named above to: (Check all that apply)

______ use or receive prescribed medication/treatment

______ self-administer prescribed medication(s) in my presence or that of an authorized staff member

in accordance with the authorized prescription.

B. 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 or a licensed pharmacist.)

C. 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.)

D. 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.

| ______________________________ | ______________________________ |
|---|---|
| Signature of Parent* | Date |
| ______________________________ | ______________________________ |
| Home Telephone | Work Telephone |

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

WILMINGTON
CITY SCHOOLS

## LICENSED PRESCRIBER'S STATEMENT

**To the Prescriber:** The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

Name of Student ______________________ School ______________________

Address ______________________ Class/Grade ______________________

City, State Zip ______________________

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student as follows:

| | |
|---|---|
| Name of medication as it appears on container in which the drug is stored: | |
| 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: | |
| Date the administration of the drug is to begin: | |
| Date the administration of the drug is to cease: | |
| Report the following side effects (i.e., severe adverse reactions) to my office immediately: | |
| Specify any special instructions for administration of the drug, including sterile conditions and storage: | |

Name of Prescriber______________________ Telephone ______________________
*(Please print)*

Prescriber's Signature______________________ Date ______________________

**Wilmington City School District**
341 S Nelson Ave
Wilmington, OH 45177
937-382-1641

Holmes (K, 1, 2) ...... Fax 937-382-2881, Phone 937-382-2750
Denver (3, 4, MH)... Fax 937-383-2711, Phone 937-382-2380
East End (PK, 5) .... Fax 937-382-1645, Phone 937-328-2443
Middle School (6-8).. Fax 937-382-3295, Phone 937-382-7556
High School (9-12)... Fax 937-382-1139, Phone 937-382-7716

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