Springfield City Schools
1500 West Jefferson St..
Springfield, Ohio 45505

PARENT RELEASE FOR THE ADMINISTRATION OF MEDICATION

Student: _____ Grade: _____

School: _____ Homeroom Teacher: _____

We (I) the undersigned who are the parent(s), foster parent(s), guardian(s), [cross out those not applicable] of the above-named student request that medication be administered to our child in accordance with the instructions of our physician

Dr. _____ (see instructions on other side of this form.)

We (I) understand that such medication will be brought to school in the original container from the pharmacist or prescribing physician.

We (I) further understand that the administration of said medication is to be done under the supervision of a member of the school staff. We (I) understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

We (I) agree to notify the school immediately, if any of the information provided by the physicin changes, or if we change physicians or medication or terminate the use of this medication for any reason.

The above-named principal or principal's designee is hereby authorized to discuss with the above-named physician conditions for administering the medication and any and all changes.

Signature of Parent/Guardian: _____

Address of Parent/Guardian: _____

Home Telephone Number: _____

Date of Signature: _____ Business Telephone: _____

(OTHER SIDE, TOP SECTION -- TO BE COMPLETED BY FAMILY PHYSICIAN.)

O.R.C. 3313.713
0-35 REV 2010

TO BE COMPLETED BY PHYSICIAN:

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by medically untrained personnel, it is requested that the medication as indicated below be administered by school personnel.

1. Name of Student _____

2. Address of Student _____

3. Medication to be administered (name, quantity, time of day, and special instructions including sterile conditions and storage.)

_____

_____

_____

4. Severe adverse reactions that, if they occur, should be reported to:

_____ physician, at _____
Telephone #

5. Dates to begin and cease medication _____ to _____
(date to begin) (date to cease)

6. Date of this request _____

7. Physician's signature _____

8. Physician's address _____

9. Physician's telephone number _____

TO BE COMPLETED BY SCHOOL PERSONNEL:

Persons authorized to administer medication:

_____

_____

_____

Principal's (or designee) Signature: _____ Date: _____