

*Kettering City School District*

**LICENSED MEDICAL PROVIDER'S REQUEST FOR DISPENSING PRESCRIPTION/NON-PRESCRIPTION MEDICATION AT SCHOOL**

*(In accordance with ORC 3313.713 and SUB S.B. No. 164)*

Medication for the student listed below cannot be scheduled for other than school hours. The administration of such medication may be supervised by medically untrained personnel. It is requested that the medication as indicated be administered by school personnel. A new form must be provided each school year.

Student Name \_\_\_\_\_ School \_\_\_\_\_

Student address \_\_\_\_\_ Grade \_\_\_\_\_

**PART I: MEDICATION TO BE TAKEN – TO BE COMPLETED BY LICENSED MEDICAL PROVIDER**

Name of Medication \_\_\_\_\_

One medication per form

Dose \_\_\_\_\_ Time to be given at school \_\_\_\_\_

Date administration is to: Begin \_\_\_\_\_ End \_\_\_\_\_

(End of school Year unless otherwise noted)

Possible reactions that, if occur, should be reported to the licensed medical provider

Special instructions if required (administration of drug, sterile conditions and storage, etc.)

Name of licensed medical provider \_\_\_\_\_ Date \_\_\_\_\_

Address of licensed medical provider \_\_\_\_\_

Phone Number \_\_\_\_\_ Emergency phone number \_\_\_\_\_

Signature of licensed medical provider \_\_\_\_\_

**PART II: PERMISSION TO CARRY ASTHMA INHALER/EPI-PEN – TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER**

If requesting permission to carry an inhaler/epi-pen, the following must be completed in addition to Part I.

The law permits a student to carry an asthma inhaler/epi-pen with the consent of the student's licensed medical provider and parent.

As the prescriber, I have determined that this student is capable of possessing and using this inhaler/epi-pen (circle one) appropriately and have provided the student with training in the proper use of the inhaler/epi-pen. The student has been instructed to immediately notify a staff member or responsible adult when the epi-pen is used.

KCS policy states 911 will be called if the epi-pen is used.

Procedures to follow in the event that the asthma inhaler/epi-pen does not produce the expected relief.

Signature of Licensed Medical Provider \_\_\_\_\_

(OVER)

*Kettering City School District*

**PART III: PARENT RELEASE FOR DISPENSING PRESCRIPTION/NON-PRESCRIPTION  
MEDICATION AT SCHOOL**

To: \_\_\_\_\_  
Principal School Name

For: \_\_\_\_\_  
Student Name

We (I), the undersigned, who are the (CIRCLE ONE) parent(s), foster parent(s), guardian(s) of  
\_\_\_\_\_ request that medication be administered to our child in

Student Name  
accordance with the instructions of our Licensed Medical Provider, \_\_\_\_\_  
(see instructions on other side of this form). **We (I), the undersigned, agree to bring the  
medication to school in a container from the pharmacist properly labeled by same, this  
label to include name of the student, licensed medical provider, date, dosage instructions  
(quantity and times), and name of medication.**

Further, we (I), the undersigned, will notify the school immediately if we change medical  
provider or medication or terminate the use of this medication for any reason. When medication  
has been discontinued, any remaining medication must be picked up by the parent within 2  
weeks after discontinuation or it will be discarded by the school nurse. **Parent must pick up  
medication by close of the last day of school or it will be discarded.**

I give permission for this information to be sent to the school nurse via facsimile. I also  
authorize the exchange of information between the licensed medical provider and the school  
nurse regarding the health care needs of my student when deemed necessary by the school nurse.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_