Firelands Christian Academy

Prescriber's Request for the Administration of Medication in School

(Prescriber's order for medication in accord with 3313.716 and 3313.716 of the Ohio Revised Code)

Student's Name ____ Date ____________________

Student's Address ___________________________ City ____________ Zip __________ Phone _____- ______- ______

School Building ____ Grade ___________________

Medication **Route** **Dose** **Time of Administration**

____
____

Starting date of this request __________________________ Termination date for medication __________________

Special instructions (if any) ____

MEDICATION WILL BE ADMINISTERED BY SCHOOL PERSONNEL (unless otherwise stated).

Adverse reactions that should be reported to the prescriber: ____
____

Adverse reactions school personnel should look for in an unauthorized user: ________________________________
____

_________________________________ ___________ ________ - _______ - ________ ______ - _____ - ________
Prescriber Signature Date Emergency phone number(s) where prescriber can be reached

FOR ASTHMATICS ONLY

STUDENT IS ALLOWED TO CARRY THEIR INHALER AND SELF ADMINISTER PER PRESCRIBERS ORDER:
YES [ ] NO [ ]

In the event the asthma medication does not produce the expected relief, please do the following: _____________
____

If the inhaler malfunctions, please do the following: ____
____

Parent/Guardian Request for the Administration of Medication in School

I request the school staff to administer the medicine to my child as ordered above by the attending prescriber. I will submit to the school a revised "Request" form signed by the prescriber and myself if there is any change in the above orders. I understand that I am required by Ohio law to provide the school with the medication in the original container as dispensed by the prescriber or pharmacist.

Parent/Guardian Signature ____ Date ___________________

Parent/Guardian Signature ____

Home Phone # ______-______-______ Work Phone # ______-______-______ Cell Phone # ______-______-______

Reminder to Parents/Guardian:
Medication must be provided to school in original container dispensed by the prescriber or pharmacist.
Please ask prescriber or pharmacist for one extra labeled container for school.

Medication Log

☐ Prescriber order on file ☐ Parent signature on file

Student ______ School ______ Date Started ______ School Year ______

Medication ______ Strength ______ Dose ______ Time ______

Special Instructions ______

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															

Initials/Signature: ______ ______ ______

Key

Initials = Med take within 1 hour of designated time

O = No medication available

X = No School

ab = Absent

er = Error

COMMENTS: