Office of Early Learning and School Readiness

Preschool and School Age Child Care Medication Form

This form meets Ohio Administrative Code. Programs may use this form or build their own including all required information

		on-prescription medication administered
Student Name:		DOB:
Student address:		
School	Grade:	Class:
To Be Completed by the Physici	an/Dentist:	
Medication Name:	·	Dose:
Dosage Time/s:	Reason for medication:	
Start date:	Stop date:	
Special Instructions:		
Potential adverse reactions to be re	eported:	
Physician/Dentist Signature:		Date:
Physician/Dentist Phone		
Number:	on for my child to receive this me	edication at school according to the
Parent/Guardian: I give permissi school district policy and as instance and am responsible to: Deliver my child's medicine to see Ensure prescription medication Ensure the medication is currer expiration Administer the first dose of any Tell the school as soon as posses Tell the school if my child gets are thanges. I agree for child's heal	on for my child to receive this meructed by my child's physician/deschool in its original container is labeled by a pharmacist or he at within the past 12 months and new medication, except in case ible if there is a change in the ustance in the modulation of the m	edication at school according to the entist. ealthcare provider provide new medication upon of emergency se of my child's medicine or dose school or any school staff person
Parent/Guardian: I give permissi school district policy and as instance and am responsible to: Deliver my child's medicine to so Ensure prescription medication Ensure the medication is current expiration Administer the first dose of any Tell the school as soon as posson Tell the school if my child gets are Have my healthcare provider conchanges. I agree for child's heal about this medicine. No other permissions.	on for my child to receive this meructed by my child's physician/deschool in its original container is labeled by a pharmacist or heat within the past 12 months and new medication, except in case ible if there is a change in the use a new healthcare provider implete a new medicine form for ithcare provider to talk with the seart of my child's medical health was necessary to the seart of my child's medical health to the search of the	edication at school according to the entist. ealthcare provider provide new medication upon of emergency se of my child's medicine my child if the medicine or dose school or any school staff person will be discussed.
Parent/Guardian: I give permissi school district policy and as install agree and am responsible to: Deliver my child's medicine to so Ensure prescription medication Ensure the medication is currer expiration Administer the first dose of any Tell the school as soon as possorell the school if my child gets are the my healthcare provider conchanges. I agree for child's heal about this medicine. No other present/Guardian	on for my child to receive this meructed by my child's physician/deschool in its original container is labeled by a pharmacist or heat within the past 12 months and new medication, except in case ible if there is a change in the use a new healthcare provider implete a new medicine form for the theore provider to talk with the seart of my child's medical health want of my child want of my child's medical health want of my child	edication at school according to the entist. ealthcare provider provide new medication upon of emergency se of my child's medicine or dose school or any school staff person

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Grade:	Class:	· ·
the student. Effect administration trai to a student a druc	tive July 1, 2011, only employees of the bo ning program conducted by a licensed hea o prescribed for the student. Except as oth	y the board are authorized to administer to a student a drug prescribed for bard who are licensed health professionals, or who have completed a dru- alth professional and considered appropriate by the board, may administe terwise provided by federal law, the board's policy may provide that certal employee shall use certain procedures, such as injection, to administer a
	مناه ما ۸ محفونستمسلم معالم مستسميلات ۸ است	cation:
Staff Trained a	ina Authorizea to Administer Medic	
	ration Training Date	

Date	Time	Dosage Amount	Reason Given/Comments	Signature of Person who Administered
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