

ADMINISTRATION OF MEDICATION
BY SCHOOL PERSONNEL - GUIDELINES

When it is necessary for school personnel to administer prescribed medication, the following guidelines, taken from the Ohio Nurses' Association Guidelines, are to be followed:

1. All school personnel must be informed that the administration of any drug (prescription or over-the-counter) without the order of the physician and the permission of the parent/guardian could be interpreted as practicing medicine and is prohibited by law.
2. The principal in each building shall appoint a responsible person or persons to supervise the storing and administering of the medication in the absence of the school nurse. All medication should be kept in a locked cabinet.
3. Written request must be obtained from the physician and the parent/guardian before any medication may be administered by school personnel. The request must include instructions as to name of medication, dosage, time, and duration of medication, and possible side effects.
4. Medication must be in original containers (child proof) and have an affixed label including the student's name, name of medication, dosage, route of administration, and time of administration.
5. New request forms must be submitted each school year, and as necessary, for changes in medication order.
6. It is advised that the medication and the signed permission forms be brought to the school by the parent/guardian.

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION

BY SCHOOL PERSONNEL

Name of Student _____ is under my care and should receive

Name of Drug, Dosage, Route _____ at the following times _____

Specific instructions for administration _____

Possible side effects to watch for _____

Expiration date of this request _____

Date _____ Physician's Signature _____

Physician's Phone Number _____

REQUEST FOR THE ADMINISTRATION OF MEDICATION

BY SCHOOL PERSONNEL: PARENT

I hereby request and give my permission to the principal or his delegate (school nurse or other responsible person) to administer the following medication to my child.

Name of Child _____

Name of Drug _____ Dosage _____ Route _____

at the following time(s) _____

Date _____ Signature of Parent or Guardian _____