FORT FRYE LOCAL SCHOOL DISTRICT
Permission to Administer Prescription Medication Form

Student Name:	Date of Birth:	
Student Address:		
School:	Grade:	School Year:
List any drug allergies/reactions:		

Medication must be in the original container. No prescription will be given at school without a current "Permission to Administer Prescription Medication Form" completed by an Ohio licensed physician and parent.

PRESCRIBER AUTHORIZATION *(To be completed by health care provider)* **Only one medication per form**

Name of medication / strength of tablet, capsule or liquid:		
Dosage:	Time/Interval:	
Date to begin medication:	Date to end medication:	Route to be given:
Reason for medication / diagnosis:		
Special Instruction:		
Possible side effects:		
Treatment in the event of an adverse reaction:		

Epinephrine Autoinjector (Epi-Pen):

☐ Student has been instructed by physician in self-administration of Epi-Pen and is competent to safely self-administer

Asthma Inhaler:

☐ Student has been instructed by physician in self-administration of asthma inhaler and is competent to safely self-administer

Parent/Guardian Signature:	**Date:**	**Phone #:**

Possible Severe Adverse Reaction(s) per ORC3317.716 and 3313.718
a) To the student for whom it is prescribed (that should be reported to the prescriber)
b) To a student for who it is not prescribed who receives a dose
Other medication instructions:
Does medication require refrigeration? ☐Yes ☐ No Is the medication a controlled substance ☐Yes ☐No
Print Name of Prescriber (Physician): Signature of Prescriber (Physician):
Address
Phone: Fax: Date:

PARENT/GUARDIAN AUTHORIZATION

☐ I authorize an employee of the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the licensed healthcare provider to talk with the prescriber or pharmacist to clarify medication order.

☐ Medication form must be received by the principal, his/her designee, and/or the school nurse. I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of the medication, dosage, strength, time interval, route of administration and the date of the drug expiration when appropriate.

Parent/Guardian Signature:	**Date:**	**Phone #:**

Form must be renewed every 12 months or whenever the prescription changes.

Revised 2/18