BETHEL-TATE LOCAL SCHOOLS
PERMIT FOR DISPENSING PRESCRIPTION MEDICATION
Required in accordance with ORC 3313.713
PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF ORAL MEDICATION DURING SCHOOL HOURS

This form is required by Ohio State Law in order for school personnel to dispense PRESCRIPTION drugs to your child.

The form must be completed by the DOCTOR in order for the medicine to be taken at school. A prescription bottle with the student's name and dosage is NOT acceptable. Notes from parents ARE NOT acceptable. Since medication for the student cannot be scheduled for other than school hours, it is requested that the oral medication, as indicated below, be administered by school personnel.

Please send this form to the school ONLY when necessary for your child to take prescription drugs at school. Provide safe transportation of the medications, prescription to and from school. **MEDICATIONS MUST BE GIVEN DIRECTLY TO A SCHOOL OFFICIAL AND MAY NOT BE SENT ON THE BUS WITH THE CHILD.**

To: Bethel-Tate School
Elementary, Intermediate, Middle or High

_____ _____
Student Name Student Address

Medication to be administered – name of medication, dosage, and time of day

_____
Possible reactions that, if they occur, should be reported to the parent and physician immediately

_____ _____
Date to begin Medication Date Medication to be continued until

_____ _____
PHYSICAN'S SIGNATURE Physician's address and phone number

School personnel will supervise the administration of oral medication in pill form only. School personnel will not assume responsibility for administering liquid medication, application of ointments, change of dressings, or injections. All medication must be brought to school in the original container, properly labeled. The child's name, physician's name, medication, dosage, and time of administration should be on the container. ***Students may not transport medication to and from school.***

TO BE COMPLETED BY THE PARENT OR GUARDIAN

I, the undersigned parent, guardian, or custodian of: _____
Request that oral medication be administered to my child according to the physician's directions above. I will notify the school if there is any medication change**. I release and agree to hold the board of education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization. I grant school personnel permission to confer with the above doctor regarding my child's health and treatment as they pertain to this medication/diagnosis.**

_____ _____ _____
Signature Relationship to child Date