Monfort Heights Elementary School
NORTHWEST LOCAL SCHOOL DISTRICT
ADMINISTRATION OF MEDICATION
(Physician’s Order and Parental Permission)

School Fax Number: 513-389-1572

School policy requires a written order from a licensed prescriber and consent of the parent/legal guardian before school personnel can give any prescribed or over-the-counter medication to a student. Please complete this form and return to the school office.

Name of Student ___________________________________________ DOB __________ Grade _______ Homeroom _______
ID # ____________________
Address ____________________________________________________ Telephone ____________________________

Allergies ___________________________________________________________________________________________

Diagnosis/condition for which medication is administered __________________________________________________

Name of medication, dose and route _______________________________________________________________________

Time or indication for administration _____________________________________________________________________

Specific instructions for administration ___________________________________________________________________

Possible side effects to be noted/reported __________________________________________________________________

Effective Date ______________________ Expiration date of this order ____________________________________________
(A new medication order must be submitted each school year)

For ASTHMA INHALERS, EPI-PENS, AND INSULIN PUMPS: In my opinion, this student shows the knowledge, understanding and ability to self-administer and be responsible for carrying the above medication during the school day. YES ______ NO _________

Instructions to follow in the event medication does not produce expected relief _______________________________________
_____________________________________________________________________________________________________

Licensed Prescriber Signature __________________________ Print Name __________________________
___/___/____                     Phone Number _______________________________________________________________________

PARENT/GUARDIAN MUST COMPLETE:
I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:
1. Submit to school personnel a revised order, signed by the licensed prescriber of the above, when any change in the original order occurs.
2. Submit to school personnel a written statement when medication has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child’s health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child comply with medication administration instructions.
5. Bring all medications to school in the original container from the pharmacist.

Adapted with permission from HCESC 5/2007
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