PORTAGE LAKES CAREER CENTER
Administration of Medication by School Personnel

The Portage Lakes Career Center Administration acknowledges that the dispensing of any drug (prescription or over-the counter) by school personnel without the order of a physician and the permission of the parent/guardian could be interpreted as practicing medicine and is prohibited by law. We strongly recommend the administration of all medications take place at home under parental supervision. Please encourage your physician to prescribe medications that can be administered during non-school hours.

In the event that medication must be administered at school the following procedure must be followed:

1) An ***Administration of Prescription Drugs Form*** must be completed by the physician and the parent/guardian for each medication. (Form available in main office)
2) An ***Authorization for Non-Prescribed Medication or Treatment Form*** must be completed by the parent/guardian for each non-prescription medication. (Form available in main office)
3) Medications must be clearly marked with the student's name and be in the original container.
4) Parent or guardian must bring the medication to the secondary office.
5) The principal shall supervise the storing and distribution of students' medication.
6) It is solely the responsibility of the individual student to report to the office at the proper time to take his/her medication.

Students at the Portage Lakes Career Center are not permitted to have any form of medication in their possession while in the building or on school grounds. Violation of this rule will result in disciplinary action as stated in the student handbook.

4/26/13

PORTAGE LAKES JOINT VOCATIONAL SCHOOL DISTRICT

Administration of Prescription Drugs

In order to administer prescription drugs to students in the public schools, there must be compliance with O.R.C. 3313.713, which requires information from both the parent/guardian and the student's physician. Parent/guardian must complete Part I and have a physician complete and sign Part II on the reverse side. The form must be filed with the school nurse before any prescription drug can be administered in school.

I. Parental Request
(Please print or type)

Name of Student: ________________________________ Birthdate: ________________

Age: ________ Grade: _______ School: ______________________________________

Telephone Number of Parent/Guardian: ____

Home address of Student: ____

____

Prescription number: ____________ Name of Pharmacy: ___________________________

I hereby request that the enumerated drug(s) prescribed by the physician named below be administered to the above-named student in accordance with O.R.C. 3313.713 and the board of education policy governing the administration of prescription drugs. I hereby agree to submit to the school nurse a revised statement signed by the physician prescribing the drug(s) if any of the information contained herein changes.

Signed this _____ day of _________, 20 ___.

Signature: _______________________________________

Relationship to student: ____________________________

SEE PGZV'RCI G" FOR PHYSICIAN'S STATEMENT

II. PHYSICIAN'S STATEMENT
(Please Print or Type)

Name of Physician: ____

Address of Physician: ____

____

Name of Drug to be Administered: ____

Dosage of Drug to be Administered: ____

Time or Intervals dosage of Drug is to be Administered: ______________________________

Date Administration of Drug is to begin: ____

Date Administration of Drug is to cease: ____

Any severe adverse reactions that should be reported to the physician:

____

____

One or more telephone numbers where physicians can be reached in an emergency:

____

Special instructions, if any, for administration or storage of the drug:

____

____

Note: <u>This statement must be revised if any of this information changes.</u>

Signature if Physician: ____

Date: ________________

PORTAGE LAKES CAREER CENTER

AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

To The Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON-PRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETE.

______________________________	______________________________
Name of Student	Address
______________________________	______________________________
School	Class/Grade

A. I am requesting permission for my child named above to use or receive the following over-the-counter medication(s):

Medication____

Dosage____

As per Board policy, all medication must be in its original container, labeled with the student's name. All medication will be kept in the front office. No medication will be kept in the student's possession.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

______________________________	______________________________
Signature of Parent	Date
______________________________	______________________________
Home Telephone	Work Telephone

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above non-prescribed medication(s)/treatment(s):

____

____
Director

PORTAGE LAKES JOINT VOCATIONAL SCHOOL DISTRICT

Administration of Prescription Drugs

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I. Parental Request
(Please print or type)

Name of Student: ________________________________ Birthdate: ________________

Age: ________ Grade: _______ School: ______________________________________

Telephone Number of Parent/Guardian: ____

Home address of Student: ____

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Prescription number: ____________ Name of Pharmacy: ___________________________

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Signed this _____ day of _________, 20 ___.

Signature: ____

Relationship to student: ____________________________

SEE REVERSE SIDE FOR PHYSICIAN'S STATEMENT

PORTAGE LAKES CAREER CENTER

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Director

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(Please Print or Type)

Name of Physician: ____

Address of Physician: ____

____

Name of Drug to be Administered: ____

Dosage of Drug to be Administered: ____

Time or Intervals dosage of Drug is to be Administered: ______________________________

Date Administration of Drug is to begin: ____

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One or more telephone numbers where physicians can be reached in an emergency:

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Special instructions, if any, for administration or storage of the drug:

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Note: This statement must be revised if any of this information changes.

Signature if Physician: ____

Date: ________________

SEE REVERSE SIDE FOR PARENTAL REQUEST