Mac-A-Cheek Learning Center

1130 W. Sandusky Ave., Bellefontaine, OH 43311
Phone - 937-404-1263 Fax - 937-292-7035

AUTHORIZATION FOR STUDENT TO RECEIVE MEDICATION OR TREATMENT

in accordance with Ohio Revised Code 3313.713

The Ohio Legislature enacted a low concerning the administration of medicine to students by school personnel. The law, Ohio Revised Code 3313.713, has established specific steps which must be taken prior to any school employee administering medication to a student. Medication must be delivered to the school in the container in which it was dispensed by the authorized prescriber or pharmacist. Over-the Counter medication must be in the original packaging. The label must include the student's name, medication, dosage, times to be administered, dates to begin and end, and any special instructions or side effects. The medication (prescription or over-the-counter) must be accompanied by written permission from the student's legal guardian and prescriber. A form for each medication or treatment must be completed. We appreciate your cooperation in complying with this requirement and school policy to help ensure the safety and health of your child.

A completed form must be provided to the school principal and/or the school nurse before the student may receive medications/treatments at school. Part A, Part B, and Part C must be completed.

PART A - PHYSICIAN (PRESCRIBER) MUST COMPLETE

Student's Name		**Date of Birth**
Student's Address	**City**	**Zip**
Medication/Treatment	**Dosage**	**Time(s) to be Given**
Adverse Reactions That Should Be Reported To Physician	**Beginning Date of Medication/Treatment Administration:**	
	Ending Date of Medication/Treatment Administration:	
Special Instructions:		

Physician's Name: _____ **Phone:** _____

Physician's Signature _____ **Date:** _____

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PART B. - PARENT/GUARDIAN MUST COMPLETE

Student's Name	**Date of Birth**

Student's Address	**City**	**Zip**

Medication/Treatment

PARENTAL AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent: The following information is necessary for any student to use prescribed medications or to receive treatment in school.

A. I am requesting permission for my child named above to use the prscribed medication/treatment in accordance with the Physician's prescription.

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

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

D. I release and agree to hold the Governing Board, 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.

Parent(Guardian)'s Name: _____ **Phone:** _____

Parent(Guardian)'s Signatu _____ **Date:** _____

PART C - SCHOOL MUST COMPLETE

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above prescribed medication or treatment.

School Nurse, Teacher, Teaching Assistant, One-to-One Assistant, Head Teacher, Principal, Registered Nurse, Licensed Practical Nurse

Principal's Signature: _____ **Date:** _____