

CARLISLE LOCAL SCHOOL DISTRICT

**Permit for Dispensing Prescription Medication
(In Accordance with Ohio Revised Code 3313.713)**

The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This section to be completed by the parent or guardian:

Name of Student _____ Birthday _____

Student's Address _____

School _____ Grade _____ Homeroom _____

I request school personnel administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibilities for results of such medication.

Parent/Guardian Signature _____ Date _____

Telephone during school hours _____ Other telephone _____

This section to be completed by the physician:

Medication _____ Date of Authorization _____

Dosage _____

Time(s) to be given _____

Date to begin _____ Date to end _____

Adverse reaction to be reported _____

Physician emergency telephone _____ Alternate telephone _____

Special instructions _____

Administration _____

Storage _____

Other _____

Prescribing physician (Print) _____

Signature _____

Physician's address _____