Carlisle Local School District

Permit for Dispensing Medication

I request school personnel to administer and/or assist in the administration of medication to my child. Including prescription medication; over-the-counter medication; emergency medications including but not limited to; inhalers, epinephrine pens, diazepam and versed. If determined appropriate by physician, student may carry inhalers and epinephrine pens. School personnel will follow instructions provided by physician and I agree to (1) deliver the medication to the school in the original container with pharmacy label (2) notify the school if I change physicians or if the medication is changed or eliminated. (3) I agree to pick up left over medication when it is terminated or by end of school year or it will be disposed of. I understand it is the student's responsibility to report on time for scheduled medication. I give permission for the school nurse to contact the physician regarding this medication administration in the school setting. I agree to hold school employees and the Board of Education free from all responsibility for results of listed medications.

To be completed by Parent/Guardian:

Name of Student_____DOB_____

Students Address_____

Allergies_____

Parent/Guardian Signature_____Date_____

Phone # during School Hours_____ Other Phone #_____

This section to be completed by the physician:

Medication_____ _____

Dosage_____ Time/Frequency_____

IF PRN list conditions needed_____

Adverse reactions to report_____

Special Instructions/Storage_____

Date to begin administration_____ Date to end_____

Prescribing Physician (Print) _____

Physician Signature_____

Physician Address _____

School Staff ONLY:

Nurse Signature_____Approved_____Denied_____Date_____
School _____Grade_____Teachers_____

In Accordance with Ohio Revised Codes 3313.713; 3313.718/3313.141; 3313.716/3313.14
Revised February 2016