

LAKE LOCAL SCHOOL DISTRICT
PRESCRIPTION Medication Request Form

Under provisions of the Ohio Revised Code, all public schools require the following information when children require administration of prescription drugs. Please complete the following information and return to the school.

Student Last Name		First	Middle
Student Address			
Building	School Year	Grade	Date of Birth
Name of Medication		Dosage/Administration Instructions	
Administration of medication to BEGIN		Administration of medication to END	
Significant side effect (adverse reactions) which should be reported to the physician:			
Special instructions for administration of the drug, include sterile conditions and storage:			
Physician's SIGNATURE	PRINT Physician's Name		Physician's EMERGENCY Phone Number

With full knowledge of any emergencies, dangers, and risks related to the administration of such medication by the Lake Local Schools employees, officers, or agents, we, the undersigned, hereby waive all claims which might arise from said administration of medication to said minor child. We hereby assume full responsibility for the administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Lake Local School District, Lake Local Board of Education, its members, offers, employees, and agents from any and all liability relative to the administration of such medication.

- 1. There must be written notification to the school if there is any change in the physician's medication order.**
- 2. Medication must be in the original container as dispensed by the physician or pharmacy.**
- 3. It is advised that the medication form and medication be brought to the school by the parent/guardian.**
- 4. The student must assume responsibility for presenting him or herself for the medication at the appropriate time.**
- 5. Parents hereby authorize school personnel to communicate with the pharmacist or physician to clarify order information and communicate student progress.**
- 6. It is the responsibility of the parent/guardian to retrieve any remaining medication at the end of the administration period (or school year). Any unclaimed medication will be disposed of prior to the next school year.**

_____/_____/_____
 Parent/Guardian Signature Date Phone Numbers (Home/Work/Cell)