WORTHINGTON SCHOOLS

Worthington, Ohio 43085

Rev. 4/2008

PARENT'S OR STUDENT'S REQUEST FOR ASSISTANCE IN THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the school nurse or his/her designee to assist in administering medication to my child. (Note that, according to Worthington School Board Policy, **all prescription medication** to be administered to pupils in Grades K-12 must be **delivered** to, **stored** in and **dispensed** from the building health office by the school nurse or nurse's designee.) The school nurse will assist in dispensing of **both prescription and over-the-counter non-prescription medication** for students in Grades K-8.

Name of Student:_____ Date of Birth:_____ School:_____ Grade:_____
Address of Student:_____

_____ _____ _____
Medication Dosage Route

Medication is to be taken at the following time(s):_____

I/We understand and acknowledge that school district personnel are under no obligation to render the assistance requested and that such assistance may, in the absence of the school nurse, be rendered by an employee of the district who is not medically trained. I/We hereby release the Worthington City School District, its Board of Education, its officials and employees, including the school nurse and the nurse's designee, from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested.

Furthermore, I/we understand the parental responsibility to be: (1) to deliver the medication to the school; (2) to notify the school if the child changes physicians; (3) to obtain a revised statement, signed by the physician who originally prescribed the drug, and to deliver it to the school when the child's therapy is changed in any manner; and (4) to recover any medication not administered by the school.

_____ _____ _____ _____
Date Signature of Student's Parent(s) or Legal Guardian(s) Home No. Work No.

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ALL MEDICATIONS MUST BE IN ORIGINAL/PHARMACY-LABELED CONTAINERS

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WORTHINGTON SCHOOLS
PHYSICIAN STATEMENT TO AUTHORIZE DISPENSING MEDICATION

To the Physician:

The Worthington Board of Education urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the receiving and consumption of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by:
Name of Student:_____

_____ _____ _____
Medication Dosage Route

Medication is to be taken at the following times:_____
Instructions or precautions:_____
Possible side effects or reactions:_____
Action to be taken if side effects observed:_____
Beginning date prescription:_____Expiration date prescription_____: Date form completed:_____

Physician's Signature:_____ Physician's Printed Name:_____
Phone #:_____ Physician's Address:_____

A new form must be completed for each change and each school year!