

To Be Completed By Parent & Physician If Medication is Taken at School

ADMINISTRATION OF PRESCRIBED AND OVER-THE-COUNTER MEDICATION TO STUDENTS

Lakewood City Schools

I. Student Name _____ School _____ Grade _____ D.O.B. _____
Address _____ Day Phone _____ Evening Phone _____

MEDICATION

(Section II – Information to be completed by Prescriber)

II. Name of Prescribed or Over-the-counter Medication and Dosage _____

Patient may carry and administer own: Inhaler Epi-Pen Ana-Kit Yes ___ No ___
This medication can be safely administered by non-medical personnel Yes _____ No _____
Number of time or intervals medication is to be administered _____
Date administration is to begin and end _____
Adverse or severe reaction that should be reported to the prescriber _____
Special instructions for administration of medication _____

Prescriber's Name _____ Prescriber's Phone _____

Prescriber's Signature _____ Date _____

Amended S.B. 262
Section 3313.713

Parent agrees to inform the principal of any revision to the
prescriber's prescription.

ONE MEDICATION PER CARD

Release of Medical Liability

We hereby authorize and consent to the administration of prescribed/over-the-counter medication to our child,
_____ at _____ School by the
officers and employers of the Lakewood Board of Education. This consent is in addition to any consent we may have
given in the Emergency Medical Authorization Form prescribed by Section 3313.172 of the Ohio Revised Code. The
attached statement from our child's physician fully describes the nature of the prescribed medication, dosages, and
times for administration.

Please regard our signatures below as our assurance that we release the Lakewood Board of Education and any and all
of its officers and employees from any and all liability for injury or damages which might or could be a consequence of
or failing to administer such prescribed medication to our child. The school officers or employees cannot be responsible
for any adverse reactions to the medication or its effectiveness.

*Further, we agree to indemnify and hold harmless the board of Education and any and all of its officers and employees
from any and all claims for injury or damage, loss for bodily injury, illness or death which might or could be a
consequence of or failure to administer such medication and against loss from any and all further claims, demands, and
actions at law or in equity that may hereafter at any time be made or brought by our child or anyone on our child's
behalf for the purpose of enforcing a future claim for damages on account of any injury sustained in consequence of or
failure to administer such medication.*

Medication must be brought in the container in which it was dispensed to the principal or designee by the **student's
parent, guardian, or other person in charge of the student.**

Parent/Guardian's Signature _____ Date _____ Day Phone _____
Evening Phone _____

*** If student is asthmatic, please complete Asthma Action Plan For School on reverse side.**



ASTHMA ACTION PLAN FOR SCHOOL

STUDENT NAME _____ **D.O.B.** _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Please circle student's known asthma triggers: **pollens** **stress/anxiety** **cold air** **exercise** **other** _____
allergy (please specify) _____

Current medications for asthma control: _____

Asthma medication to be given at school: _____

Is student capable and responsible for self-administering this medication? **Yes** **No**

May student carry inhaler? **Yes** **No**

Note: The Lakewood City School District may choose to follow more restrictive procedures regarding student's self-administration..

If an asthma attack occurs at school, follow these steps:

1. _____
2. _____
3. _____
4. _____

Other special instructions: _____

Date: _____ **Health Care Provider Signature:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that:

- If symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will activate the 911 emergency system.
- If my child does not keep an inhaler in the health office and/or self-administers medication in locations other than the health office, it is my responsibility to review with my child when he/she should come to the health office for additional medical assistance.
- If I am not available at numbers listed on reverse side side, contact:

1) Name _____ Phone number _____

2) Name _____ Phone number _____

Additional Comments: _____

Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY SCHOOL

Date received at school _____

Nurse's Signature _____ **Principal's Signature** _____