East Clinton Local Schools

MEDICATION ADMINISTRATION AUTHORIZATION

Date : ____________________ Student Name: ____________________________

____ Sabina Elementary
____ New Vienna Elementary
____ Middle School
____ High School

Grade: ____________________________

School Year: ______________________

Teacher: ___________________________

Physician Request:
The above named student is under my care and needs the following medication:

Medication: ____________________________________

Dosage: _______________________________________

Route: oral inhaled/inhaler rectal shot topical other: ________________

Time:_____________________ or before after lunch ________________

Possible side effects: ____

Start date: _______________ End date: end of school year or _______________

To be renewed at the beginning of each school year.

____________________________________ ______________________________

Physician Printed Name **Physician Signature**

Office Address and phone number:
Print or stamp

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New Vienna Elementary	Sabina Elementary	Middle School	High School
301 East Church Street	246 West Washington St.	174 Larrick Road	174 Larrick Road
New Vienna OH 45159	Sabina OH 45169	Sabina OH 45169	Sabina OH 45169
937-987-2448	937-584-5421	937-584-9267	937-584-2474
937-584-7453 FAX	937-584-7454 FAX	937-584-7452 FAX	937-584-7451 FAX

Medication Authorization

Parent Authorization

I hereby request and give permission to the school nurse, principal, or their designee to administer the above medication to my child. I will submit a revised form if any of the information changes.

Student Name: ______________________

Medication: ______________________
Dosage: ______________________
Route: ______________________
Time: ______________________

I also agree to:

_____ have the Physician's Authorization Request on the front side to be on file at the school.

_____ provide the medication to the school in its original container, labeled with the child's name, medication's name, dosage, and instructions.

_____ update the school with any medication changes.

I have received:

____ the Medication Drop-off and Pick-up Instruction Sheet.

And if applicable, I have received the Medication Administration Form for self-use of:

_____ Not Applicable   _____ inhaler   or   _____ epi-pen.

Date: __________________________

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Parent or guardian signature

Student Address: ____