



Indian Hill Board Office

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<http://www.indianhillschools.org>

NATIONALLY RECOGNIZED FOR EXCELLENCE IN EDUCATION

Indian Hill Exempted Village School District

Prescription Medication Permission

In accordance with Ohio Revised Code 3313.713, and our school medication policy, a parent/guardian consent and health care provider consent is required for all medications to be administered to a student by school personnel. **This includes over the counter medication.** All requested information must be completed in full, including the physician's signature and returned to the school health office. A written order from a physician is required for a student to carry an Epinephrine Autoinjector, inhaler or Diabetic supplies. **This permission form expires at the end of the current school year.**

This Box to be completed in full by the Parent/Guardian

Name of Student: _____ Date of Birth: _____

Student Address: _____ Grade: _____

I request school personnel to administer the medication as instructed and agree to (1) deliver the medication to the school in the original container with pharmacy label and (2) notify the school if the medication is changed or eliminated. I fully release Indian Hill School District employees from any and all claims and liability relating to the administration or non-administration of medication.

Parent Signature: _____ Date: _____

Students who carry an Epinephrine Autoinjector must supply a back up to the school nurse per ORC 3313.718. School Clinics stock Acetaminophen, Ibuprofen, Triple Antibiotic, Cough Drops, Benadryl, Caladryl, Calcium Carbonate and Hydrocortisone ointment. All other medications must be provided by the parent.

This Box to be completed in full by the Health Care Provider

Start Date: _____ Stop Date: _____

Allergies: _____ Weight: _____

Note: If dose is not indicated below for Over the Counter Medications, package directions will be followed.

___ Acetaminophen (PO every 4-6 hrs. PRN) ___ 325 mg ___ 650 mg
___ Acetaminophen JR (PO every 4-6 hrs. PRN) ___ 240 mg ___ 480 mg
___ Ibuprofen (PO every 6 hrs. PRN) ___ 200 mg ___ 400 mg ___ 600 mg ___ 800 mg

First Aid Items

___ Triple Antibiotic for minor wounds
___ Hydrocortisone cream 1% for itching
___ Caladryl clear for itching from insect bites, rashes
___ Cough drops every 2 hours PRN
___ Calcium Carbonate: indigestion, upset stomach that is minor in nature

Other Medication

Name of Drug _____ Dose _____
Route _____ Time _____ Frequency _____

Allergies

___ Diphenhydramine (PO q 4 hours minor allergic reactions) ___ 12.5 mg ___ 25 mg ___ 50 mg
___ Epinephrine Autoinjector ___ 0.15 mg ___ 0.3 mg IM into outer thigh for severe, life threatening allergic reaction

Adverse reactions which should be reported for any medication _____

Special instructions _____

Procedure to follow in the event the medication does not relieve symptoms _____

Prescriber's Printed Name _____ Prescriber's Signature _____

Prescriber's Phone Number _____ Prescriber's Fax _____

If the medication named above is an asthma inhaler or Epinephrine Autoinjector, please complete this portion for the child to self-administer. I agree that the student has been instructed in the proper use of an inhaler and/or Epinephrine Autoinjector, the expected results and possible side effects, and is capable of carrying and self-administering the medication.

YES ___ NO ___ PRESCRIBER SIGNATURE _____