Indian Hill Board Office

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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 Auto injector, 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 Auto injector must supply a back up to the school nurse per ORC 3313.718. School Clinics stock Acetaminophen, Ibuprofen, Triple Antibiotic, Cough Drops, Benadryl, Caladryl 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

Other Medication
Name of Drug_____ Dose _____
Route _____ Time _____Frequency _____

Asthma/Allergies
____ Diphenhydramine (PO q 4 hours minor allergic reactions) ____ 12.5 mg ____ 25 mg ____ 50 mg
____ Epinephrine Auto injector ____ 0.15 mg ____ 0.3 mg IM into outer thigh for severe, life threatening allergic reaction
____ Asthma inhaler _____ puffs every ____ hours PRN for coughing, wheezing or shortness of breath

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 Auto injector, 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 Auto injector, the expected results and possible side effects, and is capable of carrying and self -administering the medication.
YES ____ NO ____ PRESCRIBER SIGNATURE _____