Med Expiration ___________
HomeRoom ___________
Date Received ___________
Initials ___________

...cal Schools
...Road 40
Sullivan, OH 44880-9731
www.blackriverschools.org

Elementary – Phone: 419-736-2161 Fax: 419-736-2165
High School – Phone: 419-736-3303 Fax: 419-736-3302
Middle School – Phone: 419-736-3304 Fax: 419-736-3309
Board Office – Phone: 419-736-3300 Fax: 419-736-3308

Authorization to Dispense Prescription and Nonprescription

Before any Medication/ treatment can be given the following must be completed and received by Nurse.
Over the Counter medication can be approved by parents signature.

Student's Name ____ Date ________
Medication ____ Dose ________
Route _____________ Time ___________ Duration ______________

Reason for Medication/Treatment _______________________________________

Prescription ☐ ***Over the Counter*** ☐
Special Instructions ____
Start Date ___________ End Date ___________

Possible Side Effects ____

This student received instruction in the use of the above inhaler by my trained staff or me. I recommend that this student carry his/her inhaler on his/her person at all times. ***Yes No***

This student received instruction in the use of the above Epinephrine Device by my trained staff or me. I recommend that this student carry his/her Epinephrine device on his/her person at all times. ***Yes No***

Name of Physician ___________________________________ Phone ___________

Physician Signature ___________________________________ Date __________

I hereby request and give permission to the nurse, principal, or the principal's designee to administer the prescribed medication listed above to my child as instructed by the physician or authorized healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects. If applicable, my child may carry his/her inhaler or Epinephrine device as prescribed by physician on his/her person during school or school-related activities as stated above. My child and I are aware of the protocols and safety issues at school.

All medication must be clearly labeled and brought to the school (by Parent/ Guardian) in the original container as dispensed by the authorized healthcare provider, physician, or pharmacist. Ask the pharmacist to give you two containers if necessary. Send only the amount of medication that will be administered during school hours or school-sponsored activities. Medications will be kept in the school clinic/office or other secure storage area. New forms must be submitted each school year for any medication dispensed at school.

If any revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the nurse, principal, or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless she/he is physically or mentally unable to do so. I release and agree to hold the school and its designees harmless from any all liability or injury resulting directly/indirectly from this authorization. Refer to Ohio Revised Code (ORC) 4729.01 & 3313.713

Parent/Guardian Signature__________________________ **Phone**______________