Akron Children's Hospital

SCHOOL HEALTH SERVICES

Non-Prescription Medication Administered at School

(Any medication that is purchased over the counter)

Attach Student Picture If available

School: _____

School Year: _____

Grade/Class: _____

Student Name: _____ Date of Birth: _____

Student Address: _____

Name of Medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for Medication to be administered: _____

Form of Medication: ☐ Tablet ☐ Liquid ☐ Other

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported to parent or physician: _____

_____

Physician/Healthcare Provider Name: _____ Phone: _____

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy.

I agree and am responsible to:

- Deliver this medicine to school in its original container.
- Tell the school as soon as possible if there is a change in the use of this medicine.
- Complete a new medicine form for this medicine if there are dose changes. If medication dosage does not match the instructions on original container, a healthcare provider order is required.
- If this medication is needed for greater than 4 consecutive days a healthcare provider order is required.

I agree for child's healthcare provider to talk with the school or any school staff person about this medication if needed. No other part of my child's medical health will be discussed. When my child receives this medication I will be notified.

Parent/Guardian Signature: **Print for signature** _____ Date: _____

Parent/Guardian Phone: _____ Emergency Alternate Phone: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

Clinic Use Only: Date form received _____ Date medication received: _____ Form Complete (Y or N) _____

Notes: _____ Date Form complete: _____