MEDICATION REQUEST FORM
ST. MARGARET OF YORK SCHOOL

This form must be completed for **one-time only and daily** medications. It must be completed for both ***prescription AND over-the-counter medications*** (for example, Benadryl, Tylenol, Ibuprofen, nasal sprays, cough suppressants, topical ointments). THIS PROCEDURE IS IN COMPLIANCE WITH THE OHIO REVISED CODE 3313.713, THE OHIO NURSE'S PRACTICE ACT, AND ARCHDIOCESAN POLICY AND GUIDELINES.

This section is to be completed by the parent or guardian.

(Fields can be filled in on computer and printed when you "Download" form)

Name of student: ______________________ Birthdate: ______________

Student's address: ____

Home Phone: ______________ Grade: ______ Teacher: ______________

I request that school personnel administer the medication(s) as instructed and **agree to have an ADULT deliver the medication to the school in the original container, labeled with the student's name.** I will notify the school in the event of a change in physician or medication. ***It is the student's responsibility to report on time for this medication.*** I understand that if the physician orders an asthma inhaler for self-administration that I should provide a second inhaler to be stored in the health room (in the event the student forgets his/hers) and that the student should report use of the inhaler to the nurse for assessment of effectiveness. **I agree to hold St. Margaret of York School and its employees free from all responsibility for the administration of medication. I AGREE TO READ AND ABIDE BY THE CURRENT MEDICATION POLICY FOUND ON PAGE 26 IN THE PARENT/STUDENT HANDBOOK OR ON HEALTH ROOM WEBSITE.**

Parent/Guardian signature: ______________________ Date: ______________

Phone during school hours: ______________ Other phone: ______________

This section is to be completed by the prescriber.

Student Allergies: ____

MEDICATION 1: ____

Dosage: __________ Route: __________ Time(s) to be given: ______________

If medication to be given AS NEEDED, describe indications: ______________

____

Possible side effects: ____

Date to begin: ______________ Date to end: ______________

Adverse reactions to be reported: ______________________________

Special Instructions-Administration: ______________ Storage: ______________

MEDICATION 2: ____

Dosage: __________ Route: __________ Time(s) to be given: ______________

If medication to be given AS NEEDED, describe indications: ______________

____

Possible side effects: ____

Date begin: ______________ Date to end: ______________

Adverse reactions to be reported: ______________________________

Special Instructions-Administration: ______________ Storage: ______________

Name of prescriber: ______________ **Prescriber signature:** ______________

(Please print) **(NO STAMPED SIGNATURES)**

Prescriber phone: ______________ **Date:** ______________

(12/10)

OFFICE USE ONLY:
SCHOOL NURSE SIGNATURE______________ FORM REC'D______________ MED REC'D______________ SNAP______________