

Highland Local Schools  
3880 Ridge Road  
Medina, Ohio 44256

**Physician's Request for the Administration of Medication at School**

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by medically untrained personnel, it is requested that the oral medication as indicated below be administered by school personnel.

Name of Student: \_\_\_\_\_

Address of Student: \_\_\_\_\_

Medication to be administered (Name, quantity, and time of day):  
\_\_\_\_\_

Possible reaction(s) as that, if they occur, should be reported to the physician:  
\_\_\_\_\_

If medication is an Epipen or inhaler, has student been instructed on procedure to use medication and competent to carry on his/her person?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

If student carries an Epipen on self, the school office must have a second Epipen back-up, per Ohio State Law.

Medication to be continued as above until the following date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Telephone Number: \_\_\_\_\_    Date of this request: \_\_\_\_\_

\*The school will supervise administration of oral medication in pill form only. It will not assume responsibility for administering liquid medication that must be measured, application of ointments, or dressing changes.

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**Parent Release Form for the Administration of Medication at School**

We, the undersigned, request that medication be administered to our child in accordance with the instructions of our physician, Dr. \_\_\_\_\_. We understand that the administration of medication will be done under the supervision of a member of the school staff.

We further understand that the school personnel are not legally obligated to administer medication to any child. Therefore, we agree that the school district and its employees are free from any and all responsibility for the results of such medication or the manner in which it is administered.

We will notify the school immediately if we change physicians or medication or terminate the use of this medication for any reason.

Name of Student: \_\_\_\_\_

Relationship: \_\_\_\_\_ Parents \_\_\_\_\_ Foster Parents \_\_\_\_\_ Guardians

\*\*Signature of Father \_\_\_\_\_

\*\*Signature of Mother \_\_\_\_\_

Address of Parents \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Date of Signatures \_\_\_\_\_

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**To Be Completed By The School**

Principal's Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Person(s) Authorized to Administer Medication: \_\_\_\_\_  
\_\_\_\_\_

\*Oral medication, for release, refers to medication in pill form only. Liquid medication that must be measured can not be administered. Also, the schools will not assume the responsibility for applying ointments, or changing dressings.

\*\*Both parents must sign this release if they are living with, or have custody of, the child. If parents are separated and both still retain custody, both parents must sign. If children are on a foster home and placement is by the agency that holds custody, the agency must sign.