

**FAIRFIELD CITY SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT**

**DIASTAT GEL MEDICATION PERMIT
(In Accordance With Ohio Revised Code 3313.713)**

The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This section to be completed by the parent or guardian

Name of Student _____ Birthdate _____
 Students Address _____
 School District _____ School _____ Grade _____ Home Room _____

I request school personnel administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. **I agree to hold school employees and the Board of Education free from all responsibility for the results of such medication.**

Parent/Guardian Signature _____ Date _____

Telephone during school hours _____ Other telephone _____

This section must be completed in full by the physician

Medication _____ Date of authorization _____

Dosage _____

Time(s) to be given _____

Description of specific seizure symptoms _____

How soon should seizure stop _____

What observations are required (after administering medication) and for how long

When should 911 be called _____

Adverse reactions to be reported _____

Date to begin _____ Date to end _____

Physician emergency telephone _____ Alternate telephone _____

Special instructions:
 Administration _____
 Storage _____
 Other _____

Prescribing physician (print) _____ Signature _____
 Physician's address _____