

**FAIRFIELD CITY SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT**

**School 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 _____ Birthday _____
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 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 _____

Date to begin _____ Date to end _____

Adverse reactions to be reported

Physician emergency telephone _____ Alternate telephone _____

Special instructions:

Administration _____

Storage _____

Other _____

Prescribing physician (print) _____ Signature _____

Physician's address _____

For school use only

The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____