



# MEDICATION REQUEST FORM

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

What school building does this student attend? (Check one and note associated FAX number)

- Birch Primary School..... FAX: 440-588-5414                      Phone: 440-588-5400
- Forest Primary School..... FAX: 440-588-5429                      Phone: 440-588-5415
- Spruce Primary School..... FAX: 440-588-5444                      Phone: 440-588-5430
- Chestnut Intermediate School..... FAX: 440-588-5514                      Phone: 440-588-5500
- Maple Intermediate School..... FAX: 440-588-5529                      Phone: 440-588-5515
- Pine Intermediate School..... FAX: 440-588-5549                      Phone: 440-588-5530
- NO Middle School..... FAX: 440-588-5724                      Phone: 440-588-5700
- NO High School..... FAX: 440-588-5833                      Phone: 440-588-5800

## PHYSICIAN' S ORDER

Date: \_\_\_\_\_

(Note: All lines must be completed)

Name of Medication: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

**\*\*\*If this medication is for ASTHMA – all the sections on all the pages of this form MUST be completed\*\*\***

Form of medication / treatment:

\_\_\_\_ Tablet/capsule      \_\_\_\_ Liquid      \_\_\_\_ Inhaler      \_\_\_\_ Nebulizer      \_\_\_\_ Other

### Instructions:

**Dose:** \_\_\_\_\_ **Time to be administered:** \_\_\_\_\_

**Frequency:** (how often during the school day) \_\_\_\_\_

**Start Date:** \_\_\_\_\_ **Stop Date:** \_\_\_\_\_

Side effects to be reported to Physician: \_\_\_\_\_

Special Administration Instructions: \_\_\_\_\_

Special Storage Instructions: \_\_\_\_\_

\*For Emergency Medication Only ~ May the Student carry this medication? \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

**Physician Signature:** \_\_\_\_\_ **Print Physician's Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Address:** \_\_\_\_\_

### PARENT CONSENT:

I give permission for my child, \_\_\_\_\_, to receive medication at school according to school district policy and as instructed by the physician. (continued on the next page)

I agree to the following;

1. Deliver the medication to school in the original container.
2. Have a new form completed by the physician if there is any change in the medication (i.e. dosage, time, etc.)
3. A new request form must be submitted each academic year.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Please complete the remaining sections of this form if the medication is for ASTHMA or an inhaler)  
TO BE COMPLETED WHEN MEDICATION FOR ASTHMA IS ORDERED

**Physician is to complete the following:**

Please check student's known asthma triggers: \_\_\_\_\_ Pollens \_\_\_\_\_ Stress/Anxiety \_\_\_\_\_ Cold Air \_\_\_\_\_ Exercise  
Other triggers: \_\_\_\_\_

Medication is necessary when the student has symptoms such as: \_\_\_\_\_

Steps to be taken by school personnel if the asthma medication does not produce expected relief from the asthma attack (Required by Ohio Revised Code section 3313.716)

1. Student should be escorted to the clinic for evaluation if in another part of the school.
2. Contact parent if: \_\_\_\_\_

**3. Call 911 for immediate medical assistance for any of the following items checked:**

(Please check all appropriate boxes.)

No improvement to the condition 15-20 minutes after initial treatment with medication and a responsible relative cannot be reached.

Hard time breathing with:

- Chest and neck pulled in with breathing
- Child is struggling to breath
- Child is hunched over

Trouble walking or talking

Stops playing and cannot start activity again

Lips or fingernails are gray or blue

4. Other special physician instructions: \_\_\_\_\_

Any severe reactions that may occur to another child, for whom the inhaler is NOT prescribed, should such a child receive a dose of the medication. (Required by Ohio Revised Code 3313.716).

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician's Office Phone Number: \_\_\_\_\_

**PARENT NOTE:** If your child self-administers asthma medication in a school location other than the clinic, please note the following. **It is the parent's responsibility** to review with their child when to request additional medical assistance if the symptoms persist. The student must request to be escorted to the office or clinic.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian phone number to call in an emergency: \_\_\_\_\_