North Olmsted City Schools
Medication Authorization Form

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

STUDENT INFORMATION		
Student Name	Student's Date of Birth	School Name
Address	Grade	Teacher

MEDICATION INFORMATION- Medications must be provided in original container with a current expiration date.

Medication	Dose	Route	Time given
Diagnosis/Reason for taking medication:			
Start Date: Month_____ Day_____ Year_____ **End Date:** Month_____ Day_____ Year_____ or ☐ End of School year			
Possible side effects:			
Controlled Substance? YES NO			
Special instructions:			

PRESCRIBING HEALTH PROFESSIONAL

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

Signature	Date
Printed Name	
Phone	Fax

To Be Completed by Parent/Guardian

Please regard my signature below as my assurance that I release NOCS, psi, and all of the school's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I give permission for my child to receive medication at school according to school district policy and as instructed by the physician. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

Signature:	Date:
Printed Name:	Phone:

Received Medication	Printed Name:	Date Received:
Reviewed by DN	Printed Name:	Date Reviewed:

North Olmsted School District

Medication Release

Student Name: _____ Grade: _____

Medication Name/Strength: _____

Amount Returned to Parent/Guardian: _____

Name of person picking up: _____

Signature: _____ Date: _____ Time: _____

Clinic Staff Signature: _____ Date**: _____ Time:_____**