North Olmsted City Schools

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: _____