MEDICATION REQUEST FORM

North Olmsted High School
27301 Butternut Ridge Rd.
North Olmsted, OH 44070

Clinic Phone: 440 588-5800 X 5813 **FAX 440 588-5833**

Student: _____ Date of Birth:_____ Grade: _____

Address: _____ Phone: _____

PHYSICIAN'S ORDER – All lines **MUST** be completed Date:_____

Name of Medication: _____

Reason for Medication: _____

********** If this medication is for ASTHMA the back side 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 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: _____ Physician's Name Printed: _____

Address: _____ Phone: _____

PARENT CONSENT

I give permission for my child, _____, to receive medication at school according to school district policy and as instructed by the physician.

I agree to the following:

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

Parent/Guardian Signature: _____ Date: _____

(Please complete the BACK SIDE of this form if medication is for ASTHMA or is an inhaler)

TO BE COMPLETED BY PHYSICIAN WHEN MEDICATION FOR ASTHMA IS ORDERED

Please check student's known asthma triggers: ____ Pollen ____ 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 building.
2. Contact parent if: _____
3. **Call 911 for immediate medical assistance for any of the following items checked:**
   - ◯ No improvement 15 -20 minutes after initial treatment with medication and a responsible relative cannot be reached.
   - ◯ Hard time breathing with:
     Head 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 and 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 Office Phone Number: _____

PARENT NOTE

If your child self-administers asthma medication in a school location other that 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/guardian signature: _____ Date: _____

Parent/guardian phone number to call in an emergency: _____