BCSD
Berea City School District
EXCELLENCE · INTEGRITY · PURPOSE

BEREA CITY SCHOOL DISTRICT
REQUEST MEDICATION/TREATMENT GIVEN AT SCHOOL, SUMMER CAMP or EXTENDED CARE

Student's Name _____ Date of Birth _____

School Attending _____ Grade _____ Teacher _____

- No known medication allergies. Allergies _____

Give daily	Give as needed	Treatment/ Medication as written on bottle or package	Dosage in ml,mg,cc	Time (time, meal or bed)	Route of delivery	Reason medication is given	Start & End Dates actual dates	
	x	Motrin 100mg/	400 mg= 20 ml	Every 4 hours as needed	By mouth	Headache, pain or fever >100	8/28/18	6/6/19
		Sertraline 50mg	75mg=1.5 tabs	Lunch time	By mouth	ADHD	8/28/18	6/6/19

EXAMPLE

Special Instructions: _____

If inhaler: (please check one of the following options)

- Allow student to carry/administer own inhaler (recommended 4th through 12th and capable)
- Do Not allow student to carry own inhaler, it is to be administered and kept in clinic.

If allergy kit: (please check one of the following options, 911 will be called if Epi-Pen is administered)

- Allow student to carry/administer own Epi-Pen.
- Do not allow student to carry own Epi-Pen, it is to be administered and kept in clinic.

Adverse reaction to be reported to physician: _____

I, the undersigned, am the physician for the above named student and request they receive medication during school hours, summer camp hours, or extended care hours as ordered above. The parent/guardian is responsible to notify the clinic or extended care if the medication, dose, route or time to be given is changed or the medication is discontinued.

Physician's Signature: _____
Physician office number _____ Fax number _____
Date: _____

I, the undersigned, am the parent of guardian of the above, named student, and I hereby request he/she received medication during school hours, summer camps hours or extended care hours as ordered by his/her physician. **For the safety of my child and all other children I have read and agree to follow the requirements listed on the back of this form.** I understand that the school district and any of its personnel are absolved from any civil liability, which might be associated with the medication assistance.

Parent's Signature: _____ Date: _____
Parent's Telephone Number: _____

(Required by: Ohio Revised Code 3313.713)

Southwest General Health Center
BEREA CITY SCHOOL DISTRICT
REQUEST MEDICATION/TREATMENT GIVEN AT SCHOOL or EXTENDED CARE

Dear Parent/Guardian,

To allow students to obtain medical assistance ***for both prescribed and over the counter medication(s) including cough drops, eye drops, Tylenol and etc.*** *during school hours from a licensed School Health Specialist, the following is required:*

1. Current Health History and Emergency #s inputted on Final Forms needs to be on-file.
2. The Physician Order Sheet Form must be completed & signed by physician **and** parent/guardian.
3. **Plan ahead to get forms signed--***faxed orders will be accepted only for emergency changes* **NOT initial order.**
4. **All** student's personal medical supplies or **unexpired** medications, both prescription and over the counter must be brought in by an adult and match the physician order **EXACTLY** and given to clinic staff only
5. Supplies must be marked with student's name and must be stored by health clinic staff.
6. Children will not be permitted share medication, each student must have their own label medication whether prescription or over the counter medication.
7. We request a picture of your child with their supplies to allow us to safely identify student.
8. *Parent/Guardian will notify the health clinic staff if*: the order changes or is discontinued *(A new Physician Order Sheet is required for any changes—we are not permitted to alter the original sheet).*
9. Parent/Guardian will contact clinic staff with any questions, comments or concerns regarding care.
10. Separate Medication Assistance Form is required if student is to receive insulin (whether self-administered or staff administered) or Diastat during school.

Thank you for helping us provide a safe & healthy environment for all students!

Medication returned:

Signature of pick up person _____ Date & Time:_____

Medication destroyed:

Signature of personnel destroying: _____Date & Time: _____

Signature of personnel destroying: _____Date & Time: _____