Rocky River City School District

Medication Management Form

Student _____ Date of Birth _____ Grade _____

Address _____ Phone _____

PART 1: PHYSICIAN'S ORDER

(Note: All lines must be completed)

Date: _____

Name of Medication: _____

Reason for Medication: _____

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: Epinephrine Autoinjector or Asthma Inhaler**

Does the student know how to self administer this medication? _____ Yes _____ No

May the student carry this medication? _____ Yes _____ No

Physician Signature: _____ Print Physician Name: _____

Emergency Phone #: _____ Address: _____

PART 2: 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. Have a new form completed by the physician if there is any change in the medication (i.e. dosage, time, etc.).
3. Submit a new request each academic year.

Parent/Guardian Signature _____ Date _____

Emergency Phone Number _____

Principal's Approval _____ Date _____

Signature of Principal

As the parent having care or charge of the student, I agree to submit a revised statement, signed by the Physician who prescribed the medication, to the principal/designee if any of the original instructions or information changes. It is understood that the Rocky River City School District and any of its school personnel are absolved from any responsibility which might be associated with the administration of such medication (O.R.C. 3313.713).

Form PS/HE-12a: 2010