Lebanon City Schools Administration of Medication

Bowman , 825 Hart Road, **Fax** (513)934-2466, **Phone** 934-5855 GR1-2, **Phone** 934-5486 PS-K
Donovan Elementary, 401 Justice Avenue, **Fax** (513) 934-2467, **Phone** 934-5406
Berry Intermediate, 23 Oakwood Avenue, Fax (513) 228-0084, **Phone** 934-5707
Lebanon Junior High, 160A Miller Road, **Fax** (513) 228-1043, **Phone** 934-5309
Lebanon High School, 1916 Drake Road, **Fax** (513) 933-2150, **Phone** 934-5115

Dear Parent and Physician:

If your child must have medication of any type given during school hours, including over-the-counter medication, the following is our school's policy:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You must utilize the attached Administration of Medication permission form which must be completed by you and your child's physician if you wish for school personnel to administer the medication.
You and your physician *must complete and sign all sections of the form* or it will not be accepted. Students are not permitted to carry medication at anytime, including to and from school. If your physician feels it necessary for your child to carry an inhaler, this must be indicated on the attached form. If your physician feels it is necessary for your child to carry an epinephrine injection, then please contact your school nurse to obtain a different permission form. Please understand that if you and your physician choose for your child to carry his/her EMERGENCY medication, then you are assuming responsibility that your child has the knowledge to self-administer at appropriate times, will not allow another student to have access to the medication, and we may not be able to locate the medication in the event of an emergency. Prescription medicines must be in a pharmacy labeled bottle which contains instructions that match the physician's order on how and when to give the medication. Again, students are not permitted to carry medications, except for emergency use as stated above. **You must bring the medication to the office.** Over-the counter medications must be in the original container labeled with your child's name. The attached form **must be completed each year** for both prescription and over the counter medications.
3. You may discuss with your doctor an alternative schedule for administering medications (e.g. outside of school hours).

School personnel will not administer any medication to students until they have received a medication form completed by you and your doctor as explained above. In fairness to those giving the medication and to protect the safety of your child, there will be no exceptions to this policy. If you have any questions about the policy, please contact the school nurse at your child's building.

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION

It is necessary that ____________________________________have medication during school.

Medication	Dosage	Time	Duration

Diagnosis requiring medication: ____

If medication is "as needed", how soon can it be repeated? ____________________________

Possible reactions to be reported to physician: ______________________________________

Procedure to follow if medication does not produce relief from student's emergency:

____

____

Special instructions for administration/storage of drug:_________________________________

<u> This form may not be used to grant permission to carry and self-administer an epinephrine injection. See school nurse for a copy of the appropriate permission form.</u>**

For an inhaler, do you wish for it to be:

_____ **Carried and self-administered by student**

_____ **Stored in the office and given by trained school personnel**

Physician's Signature____ Date___________

Address____ Phone__________

____

PARENT PERMISSION AND RELEASE

Student's Name:____________________________________ Gender_____ D.O.B___________

Address____ Grade______School___________

I give permission for the medication ordered to be given at school and further agree to:

1. Deliver the medication to school. **Students may NOT transport medication.**
2. Notify the school if I change physicians and if the medication is changed or eliminated.
3. I give permission for my child to carry and self-administer inhaler **if indicated by physician above**.

Parent's Signature____________________________________ Phone__________ Date________

School Nurse____ Date_______________________

Principal Approval____

Signature of authorized personnel____

Signature of authorized personnel____

Signature of authorized personnel____