Cincinnati Public Schools

Administration of Prescription Rx Medication Form

Parent/Provider Request for School Personnel to Give Prescription Medicine

School: _____ Grade: ____ Homeroom: _____ School Fax: _____

Cincinnati Board of Education policy, Section 5330, requires consent of the parent, guardian, or eligible student 18 years or older before medication (including prescription medication, inhalers, Epinephrine, etc.) can be given to a student by school personnel. The following information is necessary to comply with this policy. Please **answer all questions** and return this completed form to your student's principal or school nurse.

Student's Name: _____ Date of Birth: _____ Home Phone: _____

Street Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

TO BE COMPLETED BY THE STUDENT'S PROVIDER (Physician/Nurse Practitioner/Dentist)

Name of Medication: _____ Dosage: _____

Time/Frequency: _____ How Administered: _____ Date to Begin: _____

Permission for this medication is only valid through the end of the current school year unless otherwise noted. EXCEPTION: For emergency medications for asthma, anaphylaxis, seizures or diabetes, this permission can be valid for 3 years. A provider order is required for any changes in this medication.

Date to Terminate Emergency Medication: _____(3 years)

Please attach an emergency action plan with procedures to be followed if emergency medication does not alleviate student's emergency.

For Epinephrine orders only: ____ I have determined that this student is capable of possessing and using this auto injector/epipen appropriately and have provided the student with training in the proper use of the auto-injector.

Severe reactions that should be reported to the physician: _____

_____

Special conditions for storage of drug: _____

Provider's Signature: _____ **Date:** _____

Provider's Name: _____ **Emergency Phone #:** _____

TO BE COMPLETED BY THE STUDENT'S PARENT OR ELIGIBLE STUDENT

The medicine must be in pill, capsule, liquid, auto-injector or inhaler form, and must be clearly marked from the pharmacist. The label must show the student's name, medication name, dosage directions, doctor, and prescription number.

Pharmacy: _____ Phone Number: _____

As the parent/guardian of this student (or eligible student), I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I will inform the school if there is a change in any of this information.

Please check the following if applicable:

For Students with Asthma:
_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student (or myself) to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school participates.

For Students with EpiPen/Twinject/Auto Injector:
_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student to possess and use an Epinephrine Auto-Injector, as prescribed, at the school and any activity, event, or program in which the student's school participates. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered**. I will provide a backup dose of the medication to the school as required by law.**

Name of Parent/Guardian/Eligible Student (please print): _____

Signature of Parent/Guardian/Eligible Student: _____ **Date:** _____

Primary Emergency Phone: _____ **Secondary Emergency Phone:** _____

Prescription Rx Medication Record 2015-16

Cincinnati Public Schools

Use one form per Medication. Fill in time and initials for each dose given.

Student's Name: _____ **2nd Identifier:** _____

Medication: _____ Dosage:_____ Route:_____ Time:_____

Dose changed (Date):_____ **New Dose:**_____

(No Student days are gray on this calendar.)

AUGUST 2015				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

SEPTEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30		

OCTOBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

NOVEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30				

DECEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

JANUARY 2016				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

FEBRUARY 2016				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29				

MARCH				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

APRIL				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
				1
4	5	6	7	8
11	12	13	14	15
18	18	20	21	22
25	26	27	28	29

MAY				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

JUNE				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	

Medication Codes:

A = Absent
W/D = Withdrawn
D/C = Discontinued
O/M = Out of Medication
U/L = Unable to Locate
R = Refused
C = Calamity Day

Signatures:

_____ Initials _____

_____ Initials _____

Signatures:

_____ Initials _____

_____ Initials _____