

Date Received:
Reviewed by:
Scanned to FACTS portfolio
(med name last name, first initial month.year)
Storage:OfficeK1Classroom

## 2023/24 Medication Administration Form

Student Name:					Birthdate:			
(one student per form)								
Medication		Prescription?	YES	NO	Refrigerate?	YES	NO	
Dosage		Route:						
Medication to	b be taken at the following time(s): no specific time- as needed							
Additional instr	ructions for administration:							
<ol> <li>As the student's parent or guardian, I agree to the statements below:         <ol> <li>I understand this request must be signed by both the physician (if prescribed medicine) and parent before administration of the medication will begin.</li> <li>I will assume responsibility for the delivery of the medication directly to the school office in the original container (as labeled by the pharmacy if prescription) and will ensure an adequate supply of the medication has been provided to the school. I understand I am not able to send medication with my student.</li> </ol> </li> <li>I agree to submit another form if there is any change in medication, dosage, and/or time medication is to be given.</li> <li>I acknowledge that school personnel are under no obligation to administer the above drug and that such assistance may be rendered by a school employee who is not medically trained.</li> <li>I release and agree to hold Cypress Christian School, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.</li> </ol>								
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FOR PRESCRIPTION MEDICATION ONLY AND TO BE COMPLETED BY A PRESCRIBER  I verify that the student listed above has been advised to take the medication according to the medication details outlined above. Initial below for additional Epinephrine autoinjector and asthma inhaler release.  Epinephrine Autoinjector: I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector. initial  Asthma Inhaler: If conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or any activity event or program sponsored by or in which Cypress School is a participant initial								
Pres	criber Printed Name	Signatu	re		D	ate		

Medication Returned Date: \_\_\_\_\_ Picked up by: \_\_\_\_\_ Staff: \_\_\_