Medication Storage: ___ Main Office ___ K1 ___ Classroom

2023/24 Medication Administration Form

Name of Student: ____ Grade: ___________

Medication: ________________________________ Dosage: ______________ Route: _____________

Medication must be taken at the following time(s): ___________________ ☐ no specific time-as needed

Other specific instructions for administration: ____

Beginning date: ____________ Ending date: ______________ Require refrigeration? ____ Yes ____ No

As the student's parent or guardian, I agree to the statements below:

1. I understand this request must be signed by *both* the physician (if prescribed medicine) and parent before administration of the medication will begin.
2. I will assume responsibility for the safe delivery of the medication to the school in the ***original container*** (as labeled by the pharmacy if prescription) and will assure an adequate supply of the medication has been provided to the school.
3. I agree to submit another form if there is any change in medication, dosage, and/or time medication is to be given.
4. 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.
5. 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.

______________________________ ______________________________ ____________

Parent/Guardian Name Signature Date

REQUIRED FOR PRESCRIPTION MEDICATION ONLY AND TO BE COMPLETED BY A PRESCRIBER

Epinephrine Autoinjector? ______ No ______ Yes, as the prescriber 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.

Asthma Inhaler? ______ No ______ Yes, 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.

I agree the information listed on this form is accurate and this student is under my care.

______________________________ ______________________________ ____________

Prescriber Name Signature Date

Medication Returned Date: _______ Picked up by:_________________ Staff: ______

Revised 2/8/23