Date Received: _____ Reviewed by: _____

Location of Storage: ___ Main Office ___K1 ___Classroom

Copy of Form sent with medication to: ___K1 ___Classroom

Cypress Christian Schools

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 10/04/2023