MEDICATION REQUEST AND AUTHORIZATION FORM

Dear Parent/Guardian:

The Brookfield School District recognizes that some students are able to attend school regularly only through the effective use of medication for the treatment of medical conditions which are not harmful to others. If possible, all such medications should be administered by the parent at home. Please discuss with your physician the possibility of your child receiving the medication on a schedule which would not require it to be administered in school. If this is not possible, it will be administered in school under the following **conditions**, which comply with Ohio Law.

1. The attached **Care Plan Form must be completed and returned to the school.** Note that the **top portion** of the form is to be **completed and signed by the parent/guardian** and the **bottom portion** of the form must be **completed and signed by the physician** who prescribed the medication. A Care Plan must be submitted for each medication (prescribed or over the-counter), and must be done on an annual basis.

2. The parent/guardian assumes the responsibility of furnishing the school with the medication, **which must be in the container in which it was dispensed** by the prescribing physician or others licensed to prescribe medication. Non-prescription drugs must also be in original containers. **Medicine not in the original container will not be dispensed**.

3. Medication that is brought to the office will be properly secured. Medication is to be conveyed to school directly by the parent/guardian. Two to four week supply is recommended. Medication **MAY NOT** be sent to school in the student's lunch box, pocket, or other means on or about his/her person. An exception to this would be emergency medications for asthma, allergies and/or other reactions.

4. The parent/guardian agrees to **immediately** furnish to the school a revised statement signed by the physician who prescribed the medication, if any of the information stated on the attached form changes.

5. It is the responsibility of the parent /guardian to claim any unused medication within one week after the school year ends or within one week after it is no longer needed. Any unclaimed medication will be destroyed. It is understood that it is the responsibility of the student to obtain his/her medication at the prescribed time. Please remind your child of this. Equipment necessary for the administration of the medication is to be supplied by the parent/guardian.

6. Ohio Law, as well as the policy of the Board of Education, states that: No employee who is authorized to administer a prescribed drug and who has a copy of the most recent statement would be liable in civil damages for administering or failing to administer the drug, unless he/she acted in a manner that would constitute, "gross negligence or wanton or reckless misconduct."

Should you have any questions, please do not hesitate to call the school.

Sincerely,

Mrs. R. Zebroski, School Nurse

CARE PLAN FORM FOR STUDENTS WITH MEDICAL HEALTH IMPAIRMENTS

SECTION A - TO BE COMPLETED BY THE PARENT

_____

CHILD'S NAME BIRTHDATE AGE ALLERGIES GRADE

_____

CHILD'S ADDRESS PHONE # SCHOOL TEACHER

We (I) the undersigned, who are the parents/guardians of the above mentioned child request that the health care service, outlined below and prescribed by the physician, be provided to our child. We (I) authorize the school to appoint a qualified designated person to give the prescribed medication, if necessary. Otherwise, we authorize our child to self-administer the medication. We (I) understand that medication is to be delivered to school by parent/guardian **only.** We (I) agree to notify the school personnel immediately if there is any change in either the child's medication regimen or the authorizing physician. We (I) have been furnished with a copy of the conditions under which this medication will be dispensed and agree to comply with them.

_____

PARENT/GUARDIAN SIGNATURE DATE

==========

SECTION B - TO BE COMPLETED BY THE PHYSICIAN **NOTE: COMPLETE ALL BLANKS**

_____

PHYSICIAN'S PRINTED NAME PHONE NUMBER

_____

PHYSICIAN'S ADDRESS

REASON FOR MEDICATION_____

MEDICATION/TREATMENT_____

DOSAGE_____TIME TO BE GIVEN_____

STUDENT MAY SELF-ADMINISTER MEDICATION_____

BEGINNING DATE_____ENDING DATE_____

ADVERSE REACTIONS THAT SHOULD BE REPORTED TO THE PHYSICIAN_____

_____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF MEDICATION (INCLUDING STERILE CONDITIONS AND STORAGE)_____

PHYSICIAN'S SIGNATURE_____

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER IN WHICH IT WAS DISPENSED.