FIRELANDS LOCAL SCHOOL DISTRICT

PARENT'S REQUEST FOR THE ADMINISTRATION OF OVER THE COUNTER MEDICATION

STUDENT'S NAME _____ DATE _____

STUDENT'S ADDRESS _____ PHONE _____

BUILDING _____ GRADE/TEACHER _____

MEDICATION TO BE ADMINISTERED _____

DOSAGE _____ TIME OF DAY TO BE TAKEN _____

SPECIAL INSTRUCTIONS _____

_____

I request that the medication as indicated be administered by school persons, who may be medically untrained. I understand the school personnel are not legally obligated to administer medication and, therefore, agree not to hold the school district or its employees responsible for the results of such medication or the manner in which it is administered.

I will submit to the school a revised "Request" form signed by the myself if there is any change in the above medication. I also understand that I must supply the school with the medication in the original container. I also understand that aspirin will not be administered under any circumstances.

_____ DATE _____
(SIGNATURE OF PARENT OR LEGAL GUARDIAN)

Home Phone _____ Work Phone _____

(Adoption Date - Oct. 14, 1986
Revised: July 11, 1994)

Firelands Local School District
Oberlin, Ohio

Medication Documentation Record

Student Name:	Gender:	Date of birth:	Grade:
Medication:			Teacher:
Dosage & Route:			Begin date:
Time*:			End date (if known):
**within 1/2 hour before or after is considered on time.*			Discontinued date:

#	Date	Day	Time	Initials	#	Date	Day	Time	Initials	Nurse/staff signature	Initials
										Medication Count	
										Initial arrival date	#
										Wasted Medication	
										Date & #	Prnt. Notif'd?
										Count sent home	
										Date	#
										Codes:	
										X = no school	
										AB = absent	
										ER = error	
										O = no medication	
										F = field trip	
										H = hold	
										# = medication count	
										EBH = empty bottle home	