SPRINGBORO SCHOOLS
People First / Always Growing / Better Together

SPRINGBORO HEALTH SERVICES

PRESCRIPTION MEDICATION FORM

To be Completed by Physician:

Student Name _____ _____ Today's Date_____

Parent Name _____ Telephone# _____

School _____ Grade/Teacher_____

Medication, dosage, and times to be administered:

_____

Possible reactions that should be reported to the physician:

_____

Special instructions, including storage and sterile requirements:

_____

Date when medication or procedures is no longer needed:

_____

_____

(Physician's Signature) (Physician's Telephone)

_____

(Physician's Address) (Date)

To be Completed by the Parent/Guardian:

I, hereby, authorize designated personnel of the Springboro Community City School District to administer the above named medication or procedure as instructed by the physician, and agree to:

1. Provide the school with the medication in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
2. Notify the school if we change physicians.
3. Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.
4. Release authorized school employees from all liability, cause of action, or any other responsibility for administering said medicines as noted above.

_____

(Parent / Guardian Signature) (Date)

_____

Completed by Clinic Staff/Medication Check In Process:

1. Student MAR created to include all student information/photo, parent signature, clinic nurse signature; SIGN IN/SIGN OUT Information
2. Student schedule reviewed: TIME OF DAY to by GIVEN: _____/ Student Location_____
3. DASL Medication Logged/Updated as needed.

I, hereby, acknowledge reading this request to administer medication; and understand its content, as well as the content of the Board policy printed on the back of this form.

_____

(Clinic Nurse Signature) (Date)