North Olmsted City Schools

NORTH OLMSTED HIGH SCHOOL
5755 Burns Rd., North Olmsted, OH 44070

Clinic Phone - 440-779-3588 **Fax - 440-777-2216**

MEDICATION REQUEST FORM

Student ____________________________________ **Date of Birth** __________________ **Grade** _______

Address ____ Phone ______________________

PHYSICIAN'S ORDER Date ________________________
(Note: All lines must be completed)

Name of Medication ____

Reason for Medication ____

*****If this medication is for ASTHMA - the back side of this form MUST be Completed*****

Form of medication/treatment:
______ Tablet/capsule _______ Liquid _______ Inhaler ______ Nebulizer ______ Other:

Instructions:

Dose______________________ **Time to be administered**____________________________

Frequency (how often during the school day)_______________________________________

Start Date___________________________ **Stop Date**____________________________

Side effects to be reported to Physician____

Special Administration Instructions____

Special Storage Instructions____

***For Emergency Medication only** ~May the Student carry this medication**?** _____**YES** _____**NO**

Physician signature__________________________Print Physician's Name_________________________

Phone Number______________________Address____

PARENT CONSENT

I give permission for my child,______________________________, to receive medication at school according to school district policy and as instructed by the physician.

I agree to the following:

1.) **Deliver medication to school in the original container.**

2.) Have a new form completed by the physician if there is any change in the medication (i.e. dosage, time, etc.).
3.) A new request form must be submitted each academic year.

Parent/Guardian Signature____________________________________ **Date**_________________

(Please Complete the BACK SIDE of this form if medication is for ASTHMA or an inhaler)
TO BE COMPLETED WHEN MEDICATION FOR ASTHMA IS ORDERED
(Continued from front side - physician to complete**)**

Please check student's known asthma triggers: ___Pollens ___ Stress/Anxiety ___Cold Air ___ Exercise
Other triggers: ____

Medication is necessary when the student has symptoms such as: ______________________________

υ **Steps to be taken by school personnel if the asthma medication does not produce expected relief from the asthma attack** (Required by Ohio Revised Code section 3313.716)

1. Student should be escorted to the clinic for evaluation if in another part of the school.

2. Contact parent if ____

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3. **Call 911 for immediate medical assistance for any of the following items checked:**
(Please check all appropriate boxes.)

θ No improvement 15-20 minutes after initial treatment with medication and a responsible relative cannot be reached.

θ Hard time breathing with:
- Chest and neck pulled in with breathing
- Child is struggling to breath.
- Child is hunched over.

θ Trouble walking or talking

θ Stops playing and cannot start activity again

θ Lips or fingernails are gray or blue

4. Other special physician instructions: ____

◆ Any severe reactions that may occur to another child, for whom the inhaler is **NOT** prescribed, should such a child receive a dose of the medication (Required by Ohio Revised Code 3313.716).

____

Physician's Signature ______________________________________ **Date** _____________________

Physician Office Phone Number ____

◆ **PARENT NOTE**: If your child self-administers asthma medication in a school location other than the clinic please note the following. **It is the parent's responsibility** to review with their child when to request additional medical assistance if the symptoms persist. The student must request to be escorted to the office or clinic.

Parent/guardian Signature ____ Date ________________

Parent/guardian phone # to call in an Emergency____