

North Olmsted City Schools
NORTH OLMSTED MIDDLE SCHOOL
27351 Butternut Ridge Rd, North Olmsted, OH 44070

Main Office # 440-779-8501

Fax # 440-801-5501

Clinic Phone # 440-779-8507

MEDICATION REQUEST FORM

Student _____ Date of Birth _____ Grade _____

Address _____ Phone _____

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

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: _____

U **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 _____

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 _____