

North Olmsted City Schools

MAPLE INTERMEDIATE SCHOOL
24101 Maple Ridge Rd., North Olmsted, OH 44070

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Jim Alexandrou
Principal

MEDICATION REQUEST FORM

Teresa Martin, RN
School Nurse

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: _____

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.)

- No improvement 15-20 minutes after initial treatment with medication and a responsible relative cannot be reached.
- Hard time breathing with:
 - Chest and neck pulled in with breathing
 - Child is struggling to breath.
 - Child is hunched over.
- Trouble walking or talking
- Stops playing and cannot start activity again
- 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 _____