

**CIRCLEVILLE CITY SCHOOLS**  
**PRESCRIPTION and/or OVER -THE COUNTER MEDICATION AUTHORIZATION FORM**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE/ROOM \_\_\_\_\_

To the Parent or Guardian: *CHS STUDENTS: AD VIL, TYLENOL, AND ASPIRIN NO LONGER REQUIRE A MEDICATION FORM SIGNED BY A PHYSICIAN.* BOTH PORTIONS OF THIS FORM MUST BE COMPLETED. THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO RECEIVES OR USES PRESCRIBED/OVER-THE COUNTER MEDICATION IN SCHOOL:

1. I am requesting permission for the student named above to receive or use medication according to the doctor's verification on this form. I have instructed my child to report to the school office to receive the medication at the designated time(s).
2. I will keep an adequate supply of medication at school.
3. I will assume the responsibility for the safe delivery of the medication to the school office either by myself or call the principal to make other arrangements.
4. I will call the school office and send a written note if my child is taken off his/her medication. I will retrieve the medication within 3 days.
5. I will bring in a completed medication authorization form for any dosage/medication/doctor changes.
6. I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone/Page \_\_\_\_\_

All medication must be in the original pharmacy dispensed/manufacture's containers. Labels must match instructions from the physician on this form. A new form must be completed for each dosage/medication/physician change. Each school year a new form must be completed for EACH medication.

**PHYSICIAN'S STATEMENT**

To the Physician:

The Circleville Board of Education urges you to schedule the administration of medication to students at times outside school hours. When that is not possible, the administration of medications will be permitted, insofar as feasible, during the school day. Medication in pill form is preferable to liquids for use in school.

\_\_\_\_\_  
Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Form of medication: Tablet/Capsule, Nebulizer, Liquid, Other \_\_\_\_\_

Diagnosis for which the medication is prescribed \_\_\_\_\_

Medication to be taken at the following time(s) \_\_\_\_\_

Instructions/precautions (including possible side effects) \_\_\_\_\_

Adverse reactions that need to be reported to the physician \_\_\_\_\_

Prescription start date \_\_\_\_\_ Prescription ending date \_\_\_\_\_

Date form completed \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Physician's printed name \_\_\_\_\_ Phone Number \_\_\_\_\_

Physician Address \_\_\_\_\_