

Columbus Preparatory Academy  
3330 Chippewa Street  
Columbus, OH 43204  
614.275.3600  
Fax: 614.275.3601

## Medication Request Form 2017-2018 School Year

### To be completed by Parent/Guardian

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Teacher: \_\_\_\_\_

I give permission for school personnel to follow the medical instructions requested for my child, \_\_\_\_\_, to receive medication at school according to school policy.

I agree to:

- Have a responsible **ADULT** deliver the medication to the school office.
- Bring prescription medication in its original container the name on the container must be your child's name and all instructions on the bottle must be the same as the Medication Request Form.
- All over the counter medication must be in the original container with your child's name written on it.
- Have a new form completed by a physician/licensed prescriber if the medication, dosage or instructions changes.
- Notify the school if we changed physician/licensed prescriber.
- Have a responsible **ADULT** pick up the medication at the end of the year.

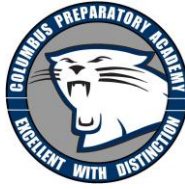
In addition to the medication on this form my child also takes the following medications: (If this is the only medication your child takes please write none) \_\_\_\_\_

My child is allergic to the following things: (If your child does not have any known allergies write none: \_\_\_\_\_

\*\*\*If your child needs and "Epi-Pen" we are required to have two (2) Epi-Pens per child. Please provide two Epi- Pens with your child's name on each pen.

I give my consent to the Physician/Licensed Prescriber, School Nurse or their designees to send and/or receive information related to my child's medication for the duration of this order as noted above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**To be completed by Physician/Licensed Prescriber for each individual medication**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Parent/Guardian Phone: \_\_\_\_\_

Name of Medication (one per form): \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Form of Medication:

Tablet/Capsule     Inhaler     Injection     Nebulizer     Liquid

Other \_\_\_\_\_

Instructions:

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Instructions for side effects \_\_\_\_\_

Restrictions: \_\_\_\_\_

Special Storage instructions: \_\_\_\_\_

**FOR EMERGENCY MEDICATION ONLY**

If the prescriber initials the line below the student may carry this medication on their person. (This means the child is able to independently administer the medication and determine appropriate times between doses.) \_\_\_\_\_

Physician/Licensed Prescriber initials

Physician/Licensed Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician/Licensed Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_