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:_____

Required by Ohio Revised Code 3313.203, 3313.56, 3313.671, 3313.712, 3313.713
Pursuant to Ohio Administrative Code 4723-13-03, 4723-13-05, 4723-13-07

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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_____