BOWLING GREEN CITY SCHOOLS

POLICY FOR DISPENSING MEDICATION

Section I

The responsibility of giving medication at school is a serious one and it is preferred that medication be given at home whenever possible. If it must be given during program hours, **the drug should be delivered to the school by the parent** and Ohio School Law requires the parent **to**:

1. Assure that the medication container is the one dispensed by the physician or pharmacist and labeled with:
   a. the student's name
   b. the name of the medication
   c. the amount of dosage
   d. time of administration
   e. the number of pills in the container at the time of delivery to the school
2. Assure that a written request, including instructions as to name of medication, dosage, time and possible side effects, signed by ***parent/guardian*** and also by the ***physician*** is on file before any medication is given.
3. Be advised that only medicine prescribed by a doctor will be given during school hours.
4. Submit a new request for each school year and as necessary for changes occurring in medication orders.

Under ***no*** circumstances will medication be dispensed without written permission or without a container identifying the student's name, the name of the medication and the dosage.

Should a medication be changed, a new written permission slip will be necessary. ***Verbal permission will not be acceptable at any time.*** If there are any questions, please contact the school your child attends.

Important: Both ***physician*** and ***parent*** must sign the form below.

Section II

Return this portion, including both the physician's and parent's request for administration by school personnel.

Student's Name: _____

Student's Address: _____

School Building: _____ Homeroom Teacher: _____ Grade Level: _____

Physician Section:

Name of medication: _____ Dosage: _____

Time/intervals medication administered: _____

Date to begin medication: _____ Date to discontinue medication: _____

Specific instructions: _____

Possible side effects: _____

_____

_____ _____ _____

Physician's Signature Date Type/Print Physician's Name

Telephone Number _____ Address _____

Parent/Guardian Section:

I authorize Bowling Green City School District staff to administer this medication and agree to:

1. ***Send and maintain*** an adequate supply of the medication to the student's school,
2. Notify the school of change in physicians,
3. Notify the school if dosage, medication, or procedure is changed or discontinued.

_____ _____ _____

Parent/Guardian's Signature Date Type/Print Parent/Guardian's Name