HILLSDALE
LOCAL SCHOOL DISTRICT
Building Character, Expecting Excellence

479 TOWNSHIP ROAD 1902
JEROMESVILLE, OHIO
44840

www.hillsdale.k12.oh.us

HILLSDALE PK-6
419-368-4364

HILLSDALE 7-12
419-368-6841

CENTRAL OFFICE
419-368-8231

Student Photo

OTC Medication Administered at School

School:_____ **School Year**: _____ **Class/Grade**: _____
Student Name:_____ **D.O.B.**: _____
Student Address:_____

To Be Completed by Parent/Guardian:

Name of medication: _____ Dose:_____ Time to be given:_____
(during school hours). Reason for medication: _____
Form of medication: Tablet _____Liquid _____Inhaler _____Nebulizer ____ Other:_____
Start Date: _____ Stop Date: _____ Special Instructions: _____
Potential adverse reactions to be reported: _____

I give permission for my child to receive this medication at school according to the school district policy and as instructed by my healthcare provider. I agree and am responsible to:

- Deliver my child's medicine to school in its original container and labeled by a pharmacist or healthcare provider
- Tell the school as soon as possible if there is a change in the use of my child's medicine
- Tell the school if my child gets a new healthcare provider
- Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.
- I agree for the child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: _____ Date:_____
Parent/Guardian Phone: _____
Emergency Alternate Phone: _____

****THIS FORM WILL EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR****