

CARROLLTON EXEMPTED VILLAGE SCHOOL DISTRICT  
252 THIRD STREET N.E., CARROLLTON, OHIO 44615-1236

**REQUEST FOR ASSISTANCE IN THE ADMINISTRATION OF NON-PRESCRIBED MEDICATION**

Some students are able to attend school only through the effective use of medication. If possible, all medication should be given under the supervision of parent/guardian outside of school hours. When this is not possible, school personnel may administer the non-prescribed medication. You must have this form filled out in full and the medication delivered to the school by the parent/guardian in the original labeled container in which it was dispensed. **Students who use medication on a daily basis, exceed dosage requirements, use the medication for a period exceeding that recommended on the labeling, indicate problems with this medication, or for whom this medication is not indicated will require documentation from a physician.**

*FORM GOOD FOR ONLY ONE WEEK*

| INFORMATION FROM PARENT/GUARDIAN   |                           |
|--|---------------------------|
| Student Name   | School                    |
| Address  | Teacher/Grade             |
| Home Telephone   | Parent/Guardian Work Tel. |
| Medical conditions and/or health concern:  |                           |
| Other medications being taken  |                           |
| Allergies  |                           |
| <p><b>The following medication needs to be administered during the school hours. I understand that unlicensed school personnel will be assisting the child with the self-administration of this medication. This medication has already been administered to this child and there has been no untoward reaction to the medication. School personnel are not liable for effects related to the use of this medication.</b></p>                                    |                           |
| Name of drug   |                           |
| Dosage and route of administration   |                           |
| The specific conditions for using this medication  |                           |
| <b>Physician Name</b><br><b>Address</b><br><b>Telephone</b>  |                           |
| <p><b>I request that this medication be administered to the student. I give permission for the principal or school nurse to contact the physician regarding the administration of this medication in the school setting. I agree to deliver the needed medication to the school in the original labeled container. I agree to pick up medication within 3 days of discontinuation or end of the school year, or school staff will dispose of medication.</b></p> |                           |
| Parent/Guardian name   | Parent Signature          |
| Address  | Date                      |
| Telephone  |                           |

***For School Use Only***

|  |
|--|
| Request Accepted _____ Request Denied _____        |
| Reason for Denial:                                 |
| Individual(s) authorized to administer medication: |
| Signature of Building Principal _____ Date _____   |