Office of Early Learning and School Readiness

# Preschool and School Age Child Care Medication Form

**This form meets Ohio Administrative Code. Programs may use this form or build their own including all required information.**

*A separate medication form is required for each prescription and non-prescription medication administered.

Student Name:_____ DOB:_____

Student address: _____

School _____ Grade: _____ Class: _____

**To Be Completed by the Physician/Dentist:**

Medication Name:_____ Dose:_____

Dosage Time/s:_____ Reason for medication:_____

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported:

_____

**Physician/Dentist Signature:**_____ Date:_____

Physician/Dentist Phone Number:_____ Fax:_____

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**Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy and as instructed by my child's physician/dentist.**

**I agree and am responsible to:**

- **Deliver my child's medicine to school in its original container**
- **Ensure prescription medication is labeled by a pharmacist or healthcare provider**
- **Ensure the medication is current within the past 12 months and provide new medication upon expiration**
- **Administer the first dose of any new medication, except in case of emergency**
- **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 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:** _____