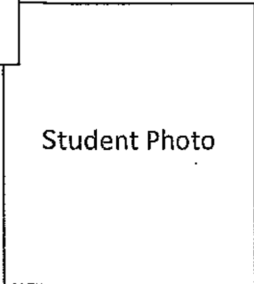

Prescription and Non-Prescription Medicine

<u>REQUEST FOR ASSISTANCE IN THE ADMINISTRATION OF MEDICATION</u>
(Ohio Revised Code 3313.713)

Part I (completed by a parent or guardian).

I/we hereby request and give permission to designed personnel to help in the self-administration of medication to my child. I am sending the medicine in the original container obtained from our physician or pharmacist. I/we understand and acknowledge that designated personnel are under no obligation to render the assistance requested and that according to ORC 3313.713, such administration will be given by personnel trained in the administration of medication and approved by the school district. There may not be any adult available for injections, catheterization or other procedures for which specific training is necessary. I/we hereby release the home school district, its board of education, its officials and employees, Mohican School in the Out-of-Doors, Inc., its board of trustees, officials and employees from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested. I/we agree to submit a revised statement signed by the physician if any information provided in Part II should change before my/our student goes to Mohican Outdoor School.

Signature of parent/guardian______________________________ **Date** ________________

Parent/Guardian's phone number ______________________________________

Part II (completed by physician if physician prescribed medicine is being sent to Mohican)

<u>Prescription and Nonprescription Medicine</u> must be in the original container per Ohio Revised Code 3313.713.

Name of Student ______________________________ School ______________________________
Name of Physician __________________________ Phone in case of emergency (   )_______________
Physician's Address ____

Please list the name of drug, dosage and time or intervals dosage of drug is to be administered.
IF GENERIC DRUG IS BEING SENT, BOTH NAMES ARE NECESSARY.
The name on this form must match the medicine sent.

Name of Prescription & Drug (generic)	Dosage	How Often <u>X/day</u>	Brkfst. *Before/ after*	Lunch *Before/ after*	Supper *Before/ after*	Bed-time	Reason For Medicine

Date drug administration begins________________Date drug administration ceases ____________________

Any severe adverse reactions that should be reported to the physician _____________________________

Special instructions, if any, for administration or storage of the drug _____________________________

____ ____________________________
Signature of Attending Physician (per ORC 3313.713) Date