

## WESTSIDE CHRISTIAN ACADEMY

### ADMINISTERING MEDICINE TO STUDENTS Prescription & Over-the-Counter Medication

In compliance with Ohio law mandating strict policy and procedures regarding the administration of medication in school settings, Westside Christian Academy requires adherence to the following.

If possible, all medication should be given by the parent at home. If this is not possible, parents may come to school to administer medication to their children. **School personnel will be permitted to administer medications only when no alternative is available.** For the purpose of this policy the term medication is defined as **any prescription or non-prescription/over-the-counter medicine.**

**Before** a student may be given medication at school the following must be received:

- **The Medication Authorization form** must be on file in the school office (this includes prescription and non-prescription medication. This form complies with Ohio revised Code 3313.73.
  - Form must be completed and signed by physician/licensed prescriber and parent/guardian
  - Parent/guardian will provide a separate form for each medicine.
  - Parent/guardian will provide a revised form if there is any change in medication, dosage or time of administration.
  - Notes from parents/guardians will not be accepted in lieu of the physician/licensed prescriber's completed request form
  - New request forms will be submitted each school year and may be obtained in the school office
  - **Parent/guardian or other responsible adult must deliver replacement medication to the school office. Medication will not be accepted from students.**
  
- **Medication must be received in the following manner:**
  - Prescription medications are to be in a current prescription bottle labeled by the pharmacist. The pharmacist will provide a bottle for the school upon parent request.
  - It must have a label affixed which includes:
    - a) Student's name
    - b) Name of medication
    - c) Dosage
    - d) Frequency of administration
    - e) Name and telephone number of pharmacy
  - If a pill is to be cut in ½, it must be cut prior to delivering it to school.
  - **Over-the counter medications** must be in an original medication bottle, clearly marked with the student's name.

**No medication will be administered to a student until all the above requirements are in place.**

At the end of the school year or when the medication is discontinued, the parent/guardian may pick up remaining medication within 5 working days. Medication that is not picked up within the allotted time will be discarded.

WESTSIDE CHRISTIAN ACADEMY  
23096 Center Ridge Road, Westlake, OH 44145  
Phone: 440-331-1300; Fax: 440-331-1301

**MEDICATION AUTHORIZATION**  
**For Prescription & Over-the-Counter Medication**

PLEASE NOTE: **YOUR DOCTOR MUST SIGN THIS FORM!!** **No medication will be given unless this form is completed.**  
Thank you!

**NO MEDICATION WILL BE GIVEN UNLESS THIS FORM IS FILLED IN COMPLETELY AND SIGNED BY BOTH PHYSICIAN AND PARENT/GUARDIAN.**

STUDENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE: \_\_\_\_\_

GRADE \_\_\_\_\_ TEACHER \_\_\_\_\_

**To be completed by Physician/Licensed Prescriber:**

NAME OF MEDICATION \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_ TIME TO BE GIVEN \_\_\_\_\_

SIDE EFFECTS OF MEDICATION SCHOOL SHOULD BE AWARE OF \_\_\_\_\_

\_\_\_\_\_

SPECIAL INSTRUCTIONS FOR ADMINISTERING MEDICATION AND/OR STORAGE

REQUIREMENTS \_\_\_\_\_

NAME OF DOCTOR PRESCRIBING MEDICATION \_\_\_\_\_

DOCTOR'S PHONE NUMBER \_\_\_\_\_

DOCTOR'S ADDRESS \_\_\_\_\_

**SIGNATURE OF PRESCRIBING PHYSICIAN** \_\_\_\_\_

EFFECTIVE FROM \_\_\_\_\_ TO \_\_\_\_\_

**To be completed by Parent/Guardian:**

I give permission for authorized school personnel to follow the medical instructions requested above for my child \_\_\_\_\_ to receive medication at school according to school policy.

Please regard my signature below as my assurance that I release Westside Christian Academy, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences of or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revisions in the physician's prescription. I have had the opportunity to ask any questions. They have been fully answered to my satisfaction.

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)