PIONEER CAREER AND TECHNOLOGY CENTER
AUTHORIZATION FOR MEDICATION ADMINISTRATION

SCHOOL YEAR _______/_______

In accordance with the provisions of Section 3313.713 of the Ohio Revised Code, and the policy of the Pioneer Board of Education, the following form must be completed in its entirety and signed by both the licensed prescriber and the parent or guardian. This form must be received by the PCTC School Nurse prior to the administration of any prescription or non-prescription drug to a student by school personnel. Both Part A and Part B **MUST** be completed.

PART A. PARENT/GUARDIAN STATEMENT (PRINT OR TYPE)

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. This form must be completed by both the parent/guardian (top section) and the licensed prescriber (bottom section).
2. Medication must be kept in the student's labeled prescription bottle (the Pharmacy may provide an extra bottle for long-term medication). The prescription label must match instructions from the prescriber. If it is a non-prescription medication, it must be in the original container. No Narcotic medications will be administered at school. See the MEDICATION ADMINISTRATION OF NARCOTICS for an explanation of restrictions and a list of medication types that cannot be given at PCTC.
3. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, ect.).

When possible please give your child's medication outside of school hours. For example, to be able to administer three doses to the child, it might be given before school, immediately after school, and before bedtime. Please contact the PCTC School Nurse at ext. 1249 if you have any questions.

STUDENT NAME ________________________________ **DATE OF BIRTH**_________________

SIGNATURE OF
PARENT/GUARDIAN_______________________________________DATE _____________

PART B. LICENSED PRESCRIBER ORDER FOR MEDICATION ADMINISTRATION AT PCTC

I verify that this medication must be taken by: ____

NAME OF STUDENT

Diagnosis for which medication is prescribed: ____

Medication _____________________ Strength ______________ Dose ___________________

Time of Administration_______________ Administration start date ____________ Expiration date ______________

Instructions or precautions, including possible side effects ______________________________
____

Licensed Prescriber's signature: ____

Licensed Prescriber's printed name: ____

Phone _____________________________________ Fax________________________________