

Louisa Wright Early Childhood Center, 600 South East Street, **Fax** (513) 934-2412, **Phone** 934-5486  
Bowman Primary, 825 Hart Road, **Fax** (513) 934-2466, **Phone** 934-5855  
Donovan Elementary, 401 Justice Avenue, **Fax** (513) 934-2467, **Phone** 934-5406  
Berry Intermediate, 23 Oakwood Street, **Fax** (513) 228-1944, **Phone** 934-5707  
Lebanon Junior High, 160 Miller Road, **Fax** (513) 932-9436, **Phone** 934-5309  
Lebanon High School, 1916 Drake Road, **Fax** (513) 933-2150, **Phone** 934-5115

Dear Parent and Physician:

If your child must have medication of any type given during school hours, including over-the-counter drugs, the following is our school's policy:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You must utilize the attached Administration of Medication permission form which must be completed by you and your child's physician if you wish school personnel to administer the medication.

**You and your physician must complete all sections of the form or it will not be accepted.** Students are not permitted to carry medication at anytime, including to and from school. If your physician feels it necessary for your child to carry a medication **for emergency purposes** only, such as an inhaler, this must be indicated on the form. Please understand that if you and your physician choose for your child to carry his/her EMERGENCY medication, then you are assuming responsibility that your child has the knowledge to self-administer at appropriate times, will not allow another student to have access to the medication, and we may not be able to locate the medication in the event of an emergency. Prescription medicines must be in a pharmacy labeled bottle which contains instructions that match the physician's order on how and when to give the medication. Again, students are not permitted to carry medications, except for emergency use as stated above, **so you must bring the medication to the office.** When empty, the bottle will be returned to you by your student so that you may refill and return it to school. Over-the-counter drugs must be in the original container labeled with your child's name. The attached form must be completed each year for both prescription and over the counter medications.

3. You may discuss with your doctor an alternative schedule for administering medications (e.g. outside school hours).

**School personnel will not administer any medication to students until they have received a medication form completed by you and your doctor as explained above.** In fairness to those giving the medication and to protect the safety of your child, there will be no exceptions to this policy. If you have any questions about the policy, please contact the school nurse at your child's building.

Lebanon City Schools  
700 Holbrook Avenue, Lebanon Ohio 45036

## PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION

It is necessary that \_\_\_\_\_ have medication during school hours. He/She must take:

Medication	Dosage	Time	Duration

Diagnosis requiring medication: \_\_\_\_\_

If medication is "as needed", how soon can it be repeated? \_\_\_\_\_

Possible reactions to be reported to physician: \_\_\_\_\_

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other emergency:

\_\_\_\_\_

\_\_\_\_\_

Special instructions for administration/storage of drug:

\_\_\_\_\_

**For an EMERGENCY medication (inhaler/epi-pen), do you wish for it to be:**

- Carried and monitored by student**
- Stored in the office and given by trained school personnel**

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

### PARENT PERMISSION AND RELEASE

Child's Name \_\_\_\_\_ Gender \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

I give permission for the medication ordered by the physician to be given at school and further agree to:

1. Deliver the medication to school.
2. Notify the school if I change physicians.
3. Notify the school if the medication or dosage is changed or eliminated.

Parent's signature \_\_\_\_\_ Phone \_\_\_\_\_ DATE \_\_\_\_\_

School Nurse approval \_\_\_\_\_

Principal approval \_\_\_\_\_

Signature of authorized personnel \_\_\_\_\_

Signature of authorized personnel \_\_\_\_\_

Signature of authorized personnel \_\_\_\_\_