Shelby County Board of Developmental Disabilities
1200 S. Children's Home Rd Sidney, OH 45365
Phone 937-498-4565 Fax 937-498-0085

CONSENT FOR MEDICATION

If it is necessary for any student to take any form of medication during the program hours, and a staff member may be needed to administer the medication, we must have written permission from the parent/guardian and the prescribing physician. **Please complete this form and return it to the program nurse as soon as possible**.

Only those medication listed below will be administered

_____ is a student at Shelby Hills ECC and has been directed by
Name of Student
_____to take the following medications while at school.
Name of Physician

_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End

It is necessary that said student take the above medication(s) during school hours; therefore, I hereby authorize the program nurses, SHECC Director or SHECC Director's designated staff to administer the above medication(s) to said student, and agree to hold the program and the staff member free and harmless from my claims or suits for damages, and for any injury or complication which may result from the prescribed administration of the above medication(s).

Staff Designated By SHECC Director to Administer to Student

_____ _____

_____ _____
Parent/Guardian Signature Date

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PHYSICIAN'S CERTIFICATE OF MEDICATION

To the Physician:
This form must be completed by you in order for the named student in our program to have medication administered to him/her. Please send the completed form to the nurse at the above address before any medication can be distributed.

Only those medications listed below will be administered

Student's Name_____ Date of Birth _____

I hereby certify that I have prescribed or directed the above named student to take the following medication(s) as detailed below:

_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End

Special Instructions for administration, including, sterile conditions and storage:

<u>Any adverse reactions shall be reported to the prescribing physician</u>

_____ _____ _____

Physician's Signature **Date** **Phone number**

_____ _____

Physician's Name (Please print) **Address**