

Dr. Robert J. Underwood

Superintendent

# Indian Lake Schools

6210 SR 235 North

Lewistown, Ohio 43333

937-686-8601 • Fax: 937-686-8421

Coleen Reprogle

Treasurer

March 2022

Students with any medication to be stored or given at school such as daily, emergency or as needed, must provide the appropriate updated Medication Administration form **each school year**. There is a form for prescription medications that doctors sign and a different form for over the counter medications that parents simply sign when they drop off the medication for school.

Please note that Medication Administration Forms are also required for medications that students **self-carry**. Ohio law only lists 3 self-carry medications for school which include inhalers, epinephrine auto injector and glucagon. **ORC 3313.718** also states that in order for students to self-carry epinephrine auto injector, a second backup is to be received by the school. There is an area on the administration form for both the doctor and parent to sign consent for the student to self-carry these medications.

Remember students are not permitted to transport medications to/from school. A parent or guardian signature is necessary for medication to be signed in/out of clinic inventory. Finally, all medication **MUST** be stored in the original container with the label matching the signed doctor's order. For questions please contact District Nurse, Kourtney Thompson at 937-686-7323.

Sincerely,

Robert J. Underwood

Superintendent



## Indian Lake Elementary School

8779 CR 91

Lewistown, Ohio 43333

Phone: 937-686-7323

Fax: 937-686-0049

Molly Hall, Principal

Pamela Scarpella, Asst. Principal

## Indian Lake Middle School

8920 CR 91

Lewistown, Ohio 43333

Phone: 937-686-8833

Fax: 937-686-8993

Melissa Mefford, Co-Principal, Operations

Erin Miller, Co-Principal, Instruction

## Indian Lake High School

6210 SR 235 North

Lewistown, Ohio 43333

Phone: 937-686-8851

Fax: 937-686-0024

Kyle Wagner, Principal

David Coburn, Asst. Principal

## ***Over the Counter Medication Authorization Form***

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Address

\_\_\_\_\_  
School

\_\_\_\_\_  
Class/Grade

- A. I am requesting permission for my child named above to use or receive the following over-the-counter medication(s).

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

My child has my permission to: **(Check this box only if you agree. You may leave it blank).**

\_\_\_\_\_ self-administer such medication(s) in the presence of an authorized staff member.

- B. I will assume responsibility for safe delivery of the medication to school.
- C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Work Telephone

### **AUTHORIZATION FOR STAFF**

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatments

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Principal