Sandusky County Board of Developmental Disabilities
1001 Castalia Street, Fremont, Ohio 43420
Phone: 419-332-9296; Fax: 419-332-9571

MEDICATION RELEASE

LICENSED HEALTH PROFESSIONAL REQUEST FOR THE ADMINISTRATION OF MEDICATION / PROCEDURE BY SANDUSKY COUNTY BOARD OF DEVELOPMENTAL DISABILITIES PERSONNEL:

_____ is under my care and should receive
Name/Date of Birth of Individual

_____
Name of Drug, Dosage, Route, Procedure Required

_____ _____
at the following time(s) While attending SCBDD/School of Hope Program(s)

Specific instructions for administration including storage and sterile requirements: _____

_____

Possible side effects and/or drug interactions:

_____

Date: _____

Expiration Date: _____

_____
Licensed Health Professional (Signature)

_____
Print Licensed Health Professional's Name

_____
Address & Phone Number

_____

PARENT'S/GUARDIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION/PROCEDURE BY SANDUSKY COUNTY BOARD OF DEVELOPMENTAL DISABILITIES PERSONNEL:

I hereby request and give my permission to the school nurse / licensed practical nurse, and / or delegated personnel to administer the following medication or procedure as instructed by the Licensed Health Professional, and agreeing: (1) To provide for, and in a timely manner, the delivery of the above prescribed medication or supplies to appropriate SCBDD/School Program; (2) To notify the School of Hope Nurse if the medication, the dosage, the time, and/or the procedure has changed, or is to be discontinued.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Nurse Signature Date

_____ _____
Teacher Signature Date