

PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS AND/OR TREATMENTS

Trumbull County Board of Developmental Disabilities – Fairhaven School
420 Lincoln Way, Niles, OH 44446

Phone: 330-652-5811

Fax – Nurse’s Office: 330-574-4517

It is recommended that whenever possible, medications and/or treatments be administered at home. When necessary, medications and treatments shall be administered during program hours according to Board Policy and procedures ***once signed permission has been submitted from the Physician and from the parent/guardian/caregiver.***

Signed permission is limited to one – which must be renewed.

Name: _____ DOB: _____ Phone: _____

Address: _____ City/State/Zip: _____

Known Allergies: *(List All)* _____

As parent/guardian/provider of the above-named student, I hereby give my permission for administration of the following: **Prescription Medication(s)** **Non-Prescription Medication(s)** **Treatment(s)** as ordered below by the attending physician. I understand the medications and treatments provided at the Fairhaven School shall be guided by the rules and guidelines of the Board Policies and Procedures.

Signature Parent/Guardian/Caregiver

Date

The above named person requires the following during Fairhaven Program hours:

Prescription Medication(s):					
Drug	Dose	Route	Exact Times to Be Given	Length of Rx <i>Beginning/End Date</i>	Reportable Side Effects
Non-Prescription Medication(s):					
Drug	Reason for Rx	Dose	Freq.	Route	Reportable Side Effects
Treatment(s): <i>Use separate order forms for gastrostomy feedings</i>					
Type of Treatment	Reason	Exact Times to Be Given	Special Instructions <i>For handling-giving or applying medication</i>	Reportable Side Effects	

Name of Physician

Signature of Physician

Date

Address of Physician

City/State/Zip

Phone Number