MEDICATION or TREATMENT AUTHORIZATION

School Year _______________

Ohio law requires ALL of the following information to enable any student to receive prescription medication or prescribed treatment in school. Preschool students must have this form completed for all prescription AND over-the-counter medication.

TO BE COMPLETED BY LICENSED PRESCRIBER

This student is under my care and should receive the following:

Name of Student: ______________________________ Date of Birth ______________________

MEDICATION/TREATMENT NAME: ____

DOSAGE: _________________TIME: __________________ ROUTE: ______________________________

DATES administration to BEGIN: _________________________ END: _________________________

Condition warranting medication/treatment: ____

Instruction or precautions including **storage** or **adverse reactions** that should be reported to the physician:

____

______________________________________ _____ _________________ ___________________

Signature of Licensed Prescriber | Title | Telephone Number | FAX Number

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FOR ASTHMA INHALERS and EPINEPHRINE AUTO-INJECTORS

Procedure to follow in the event that medication does not produce the expected relief:

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Adverse reactions for unauthorized user: ____

Student has been instructed on proper use of inhaler/ epinephrine auto-injector and is responsible to carry inhaler/ epinephrine auto-injector and self-administer (inhaler). EMS will be notified if epinephrine is used.

_______YES ________NO *A duplicate inhaler/ epinephrine auto-injector must be provided for the clinic.*

PARENT SIGNATURE:____

Licensed Prescriber Signature: ____

TO BE COMPLETED BY PARENT / GUARDIAN

Name of Student ____ Age ____ Date of Birth ______________

Address ____

Grade ________ Room ________ Teacher ____

- I am requesting my child receive the medication or treatment listed above at school functions.
- I will assume sole responsibility for safe delivery of the medication to school.
- I will supply the school with medication stored in the **original labeled container from the pharmacy** or store.
- I will supply the school with a **new medical order for any changes** for this prescribed medication or treatment.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
- I understand that any medication/supplies that are not picked up **will be discarded one week after the last day of school**.
- My signature, in accordance with HIPAA regulations, gives my permission for release of medical information to the school and/or other health care providers.

______________________________________ ___________ ____________________ ____________________

Signature of Parent / Guardian | Date | Home Phone # | Daytime Phone