School Year _____ **CANAL WINCHESTER LOCAL SCHOOLS** School Fax _____

Medication Authorization Record (5330F1)

Student Name: _____ Date of Birth: _____

Prescriber Authorization:

Medication Name: _____ Dosage: _____

Route: _____ Time/Interval: _____ Date to begin: _____ Date to end: _____

Special instructions (refrigeration, medical equipment needed, etc.) _____

Treatment for adverse reaction _____

Epinephrine Autoinjector Self-Carry Authorization

☐ Not applicable

☐ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in its proper use.

Asthma Inhaler Self-Carry Authorization

☐ Not applicable

☐ Yes, the student may possess and use the inhaler at school or any activity event or program sponsored by or in which the student's school is a participant.

Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

_____

Possible Severe Adverse Reaction(s) to this Medication

a) To the student for whom it is prescribed (that should be reported to prescriber): _____

b) To a student for whom it is not prescribed who receives a dose: _____

List any known drug allergies/reactions _____

Signature of Licensed Prescriber	**Phone**	**Fax**

Prescriber Name (Print) _____

Parent/Guardian Medication Administration Authorization:

☒ I authorize an employee of the school board to administer the above medication.

☒ I understand that additional parent/prescriber signed statements will be necessary if there are any changes.

☒ I authorize the health aide or school nurse to talk with the prescriber or pharmacist to clarify the medication order.

☒ I give permission to the health aide or school nurse to share information relating to this medication with school employees in direct contact with my child and with emergency services personnel.

☒ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time/interval, route of administration, and the date of drug expiration when appropriate.

☒ I will arrange for the safe delivery of the medication to and from school by a responsible adult.

☒ I understand that a new Medication Authorization Record is required each school year.

☒ I release and agree to hold the Board of Education, its officials, and its employees harmless from liability for damages or injury resulting directly or indirectly from this authorization.

☒ I understand that any remaining medication/supplies **will be discarded one week after the last day of school**.

Parent/Guardian Self-Carry Authorization (Check if you would like your child to have this medication with them)

☐ ***For epinephrine autoinjector:*** *I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the autoinjector to the school principal, health aide, or school nurse as required by law.*

☐ ***For asthma inhaler:*** *I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Student Address _____

Date of Birth _____ *Grade* _____ *Homeroom Teacher* _____

_____	_____	_____	_____
Signature of Parent / Guardian	*Date*	*#1 Contact Phone*	*#2 Contact Phone*