

2017/2018 Medication Authorization Form for Prescribed Medications

**Student Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List any known allergies & reactions: \_\_\_\_\_

**Prescriber Authorization:**

Name of Medication: \_\_\_\_\_ Circumstance for Use: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time Interval: \_\_\_\_\_

Date to begin medications: \_\_\_\_\_ Date to end medication: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Treatment in the event of an adverse reaction: \_\_\_\_\_

Epinephrine AutoInjector:  Not Applicable  Trained School Personnel to inject  
 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 the proper use of the autoinjector in accordance with ORC 3313.718

Asthma Inhaler:  Not Applicable  Trained School Personnel to administer inhaler  
 Yes, if conditions are satisfied per ORC 3313.716, the student may possess and use the inhaler at school or at any activity or program sponsored by or in which the student's school is a participant.

Procedures for school employees if the medication does not produce the expected relief:  
 \_\_\_\_\_

Possible Severe Adverse Reaction(s) per ORC 3313.718 and 3313.716:

a) To the student for whom the medication is prescribed: \_\_\_\_\_

b) To a student for whom the medication is not prescribed and receives a dose: \_\_\_\_\_

Other instructions: Is refrigeration required?  Yes  No      Is the medication a controlled substance?  Yes  No

→ Prescriber Signature: \_\_\_\_\_ Prescriber Name (print): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization:**

- I authorize trained school personnel to administer the above medication.
- I understand that additional parent/prescriber signed statements will be necessary if the dosage of the medication is changed.
- I authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.
- Medication forms must be received by the clinic nurse and/or trained school 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.
- When delivering the medication to the school, I must fill out a Medication Inventory Record with the clinic nurse or trained school personnel.

→ Parent/Guardian Signature: \_\_\_\_\_ Parent/Guardian Name (print): \_\_\_\_\_

#1 Contact Phone: \_\_\_\_\_ #2 Contact Phone: \_\_\_\_\_ Date: \_\_\_\_\_

- For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, 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 call 911 if this medication is administered. I will provide a backup dose of the medication to the clinic nurse as required by law per ORC 3313.718.
- For Asthma Inhaler: As the parent/guardian of this student, 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.

→ Parent/Guardian Signature: \_\_\_\_\_ Parent/Guardian Name (print): \_\_\_\_\_