PRESCRIPTION MEDICATION PERMISSION FORM

(In accordance with Ohio Revised Code 3313.713)

The use of medication during school hours is discouraged. Use this form if it is essential a student receive medication during the school day.

This Section to be Completed by the Parent or Guardian

Student's Name_____Date of Birth_____Grade_____

Student's Address_____

I request school personnel to administer the medication as instructed and agree to (1) deliver medication to the school in the original container and to (2) notify the school if I changed physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for their medication. I understand that if the physician orders an asthma inhaler for self-administration that I should provide a second inhaler to be stored in the student clinic (in the event the student forgets his/her inhaler) and that the student should report use of the inhaler to the nurse for assessment of effectiveness. I agree to hold the school employees and the Board of Education free from all responsibility for the results of such medication.

Parent/Guardian Signature_____Date _____

Phone (during school hours) _____ Other Phone _____

This Section to be Completed by the Physician

Medication_____Date of Authorization_____

Dosage_____Time(s) to be Given_____

Date to Begin_____Date to End _____

Adverse Reactions to be Reported _____

Special instructions: Administration_____Storage _____

This student may carry their asthma inhaler for self-administration. Yes _____ No _____

This student may carry their epinephrine injector for self-administration. Yes _____ No _____

The student has been instructed in the proper use of the inhaler and/or epinephrine injector, the expected results and possible side effects, and is capable of carrying and self-administering the medication.

Name of Physician (print) _____

Physician's Signature: _____

Physician's Emergency Phone: _____ **Other Phone**: _____

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