THE AMHERST EXEMPTED VILLAGE SCHOOL DISTRICT
550 MILAN AVENUE, AMHERST, OH 44001
Phone: 440-988-4406 Fax: 440-988-4413
FAX: POWERS 440-988-8674; NORD 440-988-2371; AJH 440-988-0328; HS 440-988-5087

INSTRUCTIONS: PHYSICIAN AND PARENT MUST COMPLETE AND RETURN FORM TO SCHOOL BEFORE MEDICATION WILL BE ADMINISTERED; MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN ORIGINAL CONTAINER.

STUDENT NAME | DATE OF BIRTH | AGE

ADDRESS

SCHOOL (CIRCLE ONE) POWERS NORD AJH STEELE | GRADE | TEACHER | SCHOOL YEAR

PRESCRIBER AUTHORIZATION

NAME OF MEDICATION | REASON FOR MEDICATION TO BE GIVEN AT SCHOOL

DOSAGE | ROUTE/TIMES TO BE GIVEN

BEGINNING DATE | ENDING DATE

SPECIAL INSTRUCTIONS: | REFRIGERATION NEEDED: YES_____ NO_____

ADVERSE REACTIONS/TREATMENT: | NEXT STEPS IF DESIRED EFFECT NOT MET (EMERGENCY MEDS ONLY):

EPINEPHRINE AUTOINJECTOR ___ NOT APPLICABLE ___Yes, as the prescriber I have determined that his student is capable of possessing and using this autoinjector and have provided the student with training in its proper use.

Reminder ORC 3313.718 requires backup epinephrine autoinjector be provided at school

ASTHMA INHALER ___NOT APPLICABLE ___Yes, as the prescriber I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in its proper use.

PRESCRIBER'S SIGNATURE | **DATE** | **PHONE** | **FAX**

PRESCRIBER NAME, ADDRESS (STAMP)

PARENT 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 any medication changes occur. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify any discrepancies. I also understand that all medications must be transported to school by parent/guardian, it must be in the original container, properly labeled by dispenser with student's name, prescriber's name, name of medication, dosage, strength, time interval, route and expiration date. I understand that this is in compliance with ORC 3313.713.

SELF CARRY AUTHORIZATION: I authorize child to possess and use above prescribed medication: ( )epinephrine autoinjector - I also understand that a school employee will request assistance from an emergency service provider in the event that the medication is administered. ( )asthma inhaler - the student has been instructed in its proper use.

PARENT NAME (PRINT) | CONTACT PHONE #1

PARENT SIGNATURE | DATE | CONTACT PHONE #2