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

INSTRUCTIONS: PHYSICAN 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

PERSCRIBER AUTHORIZATION

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

DOSAGE (mg, ml, etc…) | 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_____ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector and have provided the student with training in its proper use _____Not applicable

Reminder ORC 3313.718 requires backup epinephrine autoinjector be provided at school

ASTHMA INHALER_____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 _____Not Applicable

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

PERSCRIBER 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 perscribed 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)

PARENT SIGNATURE | DATE | CONTACT PHONE #1 | CONTACT PHONE #2