Gallia County Local Schools

Parental Authorization and Release/Physician's Request for the Administration of Prescription Medication by School Personnel

Student's Name_____School_____Grade_____

Address_____Date_____

Physician's Name_____Phone_____#2Phone_____

Name and Dosage of Medication_____

Time/given_____ Length (Begin date)_____(End Date)_____

Special Instructions_____

Reactions to report_____ _____

(physician's signature)

The above named child is a student in the Gallia County Local School District (GCLSD). I/We recognize that it is my/our responsibility to administer any medication that my/our child may require during school hours.

I/We hereby authorize and request the GCLSD and any of its designated employees to administer the following drugs or medication to my/our child. I will deliver the medication to school and submit to school personnel a revised statement signed by the prescribing physician if any of the information provided by the physician changes.

It is necessary that the above named student take medication during school hours. I will notify the school if the medication, the dosage or the procedure is to be changed or eliminated.

In consideration for the GCLSD and its designated employees administering the prescribed medication to my/our child as I/We are unable to do so during school hours, I/We in behalf of ourselves and our heirs, administrators, executors, successor, assigns and our child do hereby fully and forever release, acquit and discharge the GCLSD Board of Education, the board members individually and the employee/s of said liability, actions, causes of actions, claims and demands of whatever kind or nature that I/We may have in behalf of myself/ourselves and my/our named child on account of any and all injuries, losses and damages which my child may sustain from the administration the prescribed medication as administered by an employee of the GCLSD.

School personnel approved by the Board of Education are herewith authorized to administer the medication or procedure as instructed by the physician.

I AGREE TO:

1. Deliver the medication that is to be dispensed in the container which was provided by the prescribing physician/licensed pharmacist.
2. Provide written notice to the school by the physician if the medication, dose, or procedure is changed.

Parent/Guardian _____Date_____

(signature)

Signatures of persons authorized to administer medication or procedure:

_____	_____	_____
(signature)	(initial)	(date)
_____	_____	_____
(signature)	(initial)	(date)

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, 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 medication to the school principal or nurse as required by law.

Parent /Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use **of the epinephrine autoinjector**
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 reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

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.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

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Ohio Department of Health

Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716/3313.14

A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

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	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

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

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the physician)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

Physician signature	Date
Physician name	Physician emergency telephone number ( )

Adapted from the Ohio Association of School Nurses