

53303 F3 Fidelity Health Services Prescription Medication Authorization  
In accordance with Ohio Revised Code 3313.713. A new permit is required every year

**THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN**

Name of Student \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Student 's address: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Home Room: \_\_\_\_\_

- A. I am. requesting permission for my child named above: *(Check all that apply)*  
\_\_\_\_ Receive medication from an authorized Staff member. In accordance with the authorized prescription written below.  
\_\_\_\_ Carry & self-administer an asthma inhaler and/or Epinephrine autoinjector in accordance with the authorized prescription below.  
\_\_\_\_ Receive prescribed treatment in accordance with the authorized prescription below.
- B. I will assume responsibility for safe delivery of the medication/drug to school. Medication may not be sent to school in the student 's lunch box, pocket, backpack, or any other means on or about his/her person. The medication/drug must be received by the district (i.e., The person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or pharmacist or in its original over the counter container.
- C. I will notify the school immediately if the medication/drug or prescribed treatment changes. I understand a new school medication permit must be completed and submitted to school each time changes are made to the prescription or treatment.
- D. I release and agree to hold the Board of Education, its officials, and its employees harmless from all liability foreseeable, unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

\*If the licensed provider authorizes the student to carry and self-administer an asthma inhaler or an epinephrine autoinjector:

- Parent/Guardian will provide a backup dose of medication (Epinephrine) to the school principal or nurse as required by law.
- It is strongly recommended that Parent/Guardian provide a second inhaler to be stored in the clinic in the event the student does not have his/her inhaler.
- The student should be responsible for reporting the use of the inhaler to the nurse and/or principal.
- The parent/guardian must sign and date the Carry/self-administer box below and the licensed prescriber must check the Carry/Self-administer Authorization.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Phone during school \_\_\_\_\_ another phone \_\_\_\_\_ cell phone \_\_\_\_\_

**Parent/Guardian Authorization for child to Carry/Self-Administer an Epinephrine Autoinjector or Asthma Inhaler.**

- For Epinephrine Autoinjector: 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 participant. I understand that the school employee will immediately request assistance from an emergency medical provider if this medication is administered.
- 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, any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY A LICENSED PROVIDER**

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above-named student.

Medication: \_\_\_\_\_ Date of Authorization \_\_\_\_\_  
Dosage: \_\_\_\_\_ Time(s) to be given: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_

**\_\_\_\_ AUTHORIZATION FOR CHILD TO CARRY/SELF-ADMINISTER AN ASTHMA INHALER OR EPINEPHERINE AUTOINJECTOR AS PRESCRIBED**

Adverse reactions to be reported \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Licensed prescriber emergency telephone \_\_\_\_\_ Alternate telephone: \_\_\_\_\_

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

Administration: \_\_\_\_\_

Storage: \_\_\_\_\_

Other: \_\_\_\_\_

Prescriber name (print): \_\_\_\_\_ Signature: \_\_\_\_\_

Prescriber address: \_\_\_\_\_

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**FOR SCHOOL USE ONLY**

The following school personnel have read this form and are authorized to administer the medication as outlined

Nurse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_