Authorization for Administration of Over-the Counter Medications at School

This form expires at the end of the current school year (2024-2025).

Student's Name _____ Date of Birth _____ School Year _____

Street Address _____ Apt. No. _____ City _____ State _____ Zip _____

School _____ Grade _____ Homeroom _____

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. *Physician to complete dosage and time/frequency)

Over-the-Counter Medication (Parent to Complete)	**Circle**		**Dosage (Physician to complete)**	**Time/Frequency (Physician to complete)**
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician / Nurse Practitioner / Dentist) *Complete dosage and frequency above.

Provider's Signature:_____Date: _____

Provider's Name:_____ Emergency Phone _____

I give permission to the Cincinnati Health Department school nurse or Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Health Department or Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Signature of Parent or Guardian Date

_____

Please Print Name of Parent or Guardian

How can we reach you during school hours?

Work Phone _____ Cell Phone _____ Home Phone _____ Other _____

Authorization or Administration of Prescription Medication Form

Parent/Provider Request for School Personnel to Give Prescription Medicine

School:_____Grade:_____Homeroom:_____School Fax: _____

Cincinnati Board of Education policy, Section 5330, requires consent of the parent, guardian, or eligible student 18 years or older before medication (including prescription medication, inhalers, Epinephrine, etc.) can be given to a student by school personnel. The following information is necessary to comply with this policy. **Please answer all questions and return this completed form to your student's principal or school nurse.**

Student's Name:_____Date of Birth:_____Home Phone: _____

Street Address:_____Apt. #:_____City:_____State:_____Zip: _____

TO BE COMPLETED BY THE STUDENT'S PROVIDER (Physician / Nurse Practitioner / Dentist)

Name of Medication:_____Dosage:_____

Time/Frequency:_____How Administered:_____Date to Begin: _____

Permission for this medication is only valid through the end of the current school year unless otherwise noted. EXCEPTION: For emergency medications for asthma, anaphylaxis, seizures or diabetes, this permission can be valid for 3 years. A provider order is required for any changes in this medication.

Date to Terminate Emergency Medication: _____ (3 years)

Please attach an emergency action plan with procedures to be followed if emergency medication does not alleviate student's emergency.

For Epinephrine orders only: I have determined that this student is capable of possessing and using this auto injector/epipen appropriately and have provided the student with training in the proper use of the auto-injector.

Severe reactions that should be reported to the physician: _____

Special conditions for storage of drug: _____

Provider's Signature:_____**Date:**_____

Provider's Name:_____**Emergency Phone #:** _____

TO BE COMPLETED BY THE STUDENT'S PARENT OR ELIGIBLE STUDENT

The medicine must be in pill, capsule, liquid, auto-injector or inhaler form, and must be clearly marked from the pharmacist. The label must show the student's name, medication name, dosage directions, doctor, and prescription number.

Pharmacy:_____Phone Number: _____

As the parent/guardian of this student (or eligible student), I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I will inform the school if there is a change in any of this information.

Please check the following if applicable:

For Students with Asthma:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student (or myself) 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 participates.

For Students with EpiPen/Twinject/Auto Injector:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student to possess and use an Epinephrine Auto-Injector, as prescribed, at the school and any activity, event, or program in which the student's school participates. 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 as required bylaw.**

Name of Parent / Guardian / Eligible Student (please print):

_____

Signature of Parent / Guardian / Eligible Student:_____**Date:**_____

Primary Emergency Phone: _____**Secondary Emergency Phone:** _____

Cincinnati Health Department
School and Adolescent Health Program
Consent Form for 2024-2025 Seasonal Influenza Vaccine

COMPLETE THIS FORM ONLY IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE

A. SCHOOL NAME: _____

STUDENT NAME (Last)	**(First)**			**(M.I.)**	**GRADE/HR**
DATE OF BIRTH	**AGE**	**GENDER** **M / F**	**RACE**	**PHONE NUMBER**	
STREET ADDRESS	**CITY**		**STATE**	**ZIP**	

INSURANCE STATUS:
☐ **Medicaid** ☐ **CareSource** ☐ **United Healthcare Community Plan** ☐ **Molina** ☐ **Paramount** ☐ **Buckeye**
☐ **No Insurance** ☐ **Private Insurance** _____ **Insurance Billing#**_____
Medical Card Billing Number# _____ **Child's SS#**_____
*No student will be denied the flu vaccine due to inability to pay or lack of insurance

B. In order to determine if your child needs a booster dose, please answer this question**:**

1. Did your child receive **2 doses** of seasonal flu vaccine since July 2010? ☐ Yes ☐ No ☐ Unsure

C. Please answer all of the following questions:

	YES	**NO**
1. Is the student sick today with fever or respiratory illness?	☐	☐
2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?	☐	☐
3. Has the student ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	☐	☐

D. Please answer all of the following questions:

	YES	**NO**
1. Does the student have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	☐	☐
2. If the student is between the ages of 2 and 4 years old, in the past 12 months has a health care provider told you that he or she had wheezing or asthma?	☐	☐
3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?	☐	☐
4. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐	☐
5. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?	☐	☐
6. Is the student receiving anti-viral medications?	☐	☐
7. Is the person pregnant or could become pregnant in the next month?	☐	☐
8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or Flu Mist? If yes, give type and date. Recent Vaccinations: _____ Date received: _____	☐	☐

E. Consent

CONSENT FOR VACCINATION:
I understand I will receive the **Flu Vaccine Information Statement** and be offered the **Cincinnati Health Department Notice of Privacy Practices prior to my child receiving the vaccine.**

I GIVE CONSENT for the student named at the top of this form to receive the Flu vaccine.

Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year_____
Print Name of Parent Legal/Guardian_____
Parent Cell Phone Number: _____

F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY):

Vaccine	**Date Dose Administered**	**Route**	**Lot Number**	**Name and Title of Vaccine Administrator**
2024 Seasonal Flu	/ /2024	L Arm R Arm ☐ IM		
Booster Dose	/ /2023	L Arm R Arm ☐ IM		