

PRESCRIPTION MEDICATION ORDERS



Cincinnati Country Day School
6905 Given Road, Cincinnati, OH 45243
(513) 979-0250 Phone (513) 527-7638 Fax

This form will remain valid for one calendar year from the date of the physician's signature, unless otherwise noted.

Student Name	Date of Birth	Grade/Division
Medication	Dosage	Time

Does this medication require refrigeration? ☐ Yes ☐ No

☐ This medication is prescribed for short-term use. Start Date: End Date:

Possible Reactions/Side Effects/Special Instructions:

EPI-PEN, INSULIN, OR INHALER SELF CARRY SECTION

Does this student need to carry this medication at all times? ☐ Yes ☐ No

As the prescriber, I have determined that this student is competent to possess and use the prescribed medication correctly. I have also provided the student with training on the proper usage of the device.

Initial:

Procedures for school staff if a student cannot self-administer medication or it fails to provide expected relief:

Prescriber's Signature (required)

Prescriber's ER Phone #

Date

Prescriber's Name and Address (Print)

PARENT PERMISSION

I authorize the employees of Cincinnati Country Day School or HCESC to administer the medication specified above and to communicate with the prescribing physician or pharmacist for clarification regarding the medication order.

Furthermore, I agree to the following:

- Provide the medication to the school nurse in a properly labeled pharmaceutical container.
- Submit a revised form if any of the information provided by the prescriber changes.
- Release Cincinnati Country Day School from any liability related to the administration or non-administration of the medication to the student.

Parent Guardian Signature (Required)

#1 Contact Phone

#2 Contact Phone

Date

☐ 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. If the medication is not able to be administered, the school will immediately request assistance from an emergency medical service provider. **I will provide a backup dose of the medication to the school principal or nurse as required by law (ORC 3313.718).**

Initial:

☐ 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.

Initial:

Medications will not be administered without a signed medication order on file from the physician.