AUTHORIZATION FOR MEDICATION: Prescription Medication

***Student's Name:** _____ ***Date of Birth:** _____

*** Home Address:** _____

***School:** _____ ***Grade:** _____ ***Class:** _____

School Phone #: _____ **School Fax#:** _____

Allergies: _____

Diagnosis: _____

*MEDICATION	*DOSAGE	*ROUTE	*FREQUENCY	*SPECIFIC TIMES	*SPECIAL INSTRUCTIONS/ SIDE EFFECTS

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, reactions, etc.) :

_____

_____ _____

***Prescriber's Name (Printed)** ***Prescriber's Signature**

_____ _____

***Prescriber's Telephone & Fax Numbers** ***Date of Administration to Begin**

_____ _____

Prescriber's Office Address ***Date of Administration to Cease**

PARENTAL PERMISSION FOR MEDICATION

(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

My student has permission to have the prescribed medication to be used during school hours, including when they are away from school property for official school events. I understand that the medication will be kept in the health office or with an authorized staff member when away from school property.. I give my permission for the prescribed medication to be administered by an employee of the Board who are licensed health professionals, or who have completed a drug administration training program conducted by a licensed health professional and are designated by the Board. If my child has been authorized by their prescriber to self-administer their medication for asthma care, diabetes care, or anaphylaxis, I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the board, or person designated by the board, to perform the administration of the medication.

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

NOTE:

- Medications must be supplied in the original container. Ask the pharmacist to divide the medication into two labeled containers, providing one for home and one for school.
- School personnel may administer prescribed medications authorized by a prescriber and parent/ guardian.
- It is your responsibility to notify the school when there is a change in medication regimen.

_____ _____

Parent / Guardian Name (Printed) Signature of Parent / Guardian

_____ _____

Date Signed Best Number(s) to be reached

District Nurse Approval _____ Date: _____

Information required by ORC 3313.713 effective March 20, 2025