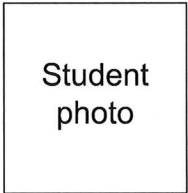




Aurora City School District
Medication Administration Form
Non-emergency medications/OTC medications



Student Information

Student Name:		Date of birth:	
Address:			
School	Grade	Teacher	School year
List any known drug allergies/reactions:			

Prescriber Authorization

Name of medication		Circumstances for use	
Dosage	Route	Time/interval	
Date to begin medication		Date to end medication	
Special Instructions			
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) to the student for whom it is prescribed (that should be reported to the prescriber) <hr/> b) To a student for whom it is not prescribed who receives a dose			
Other medication instructions Does medication require refrigeration <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescriber signature		Date	Phone
Prescriber name (print)			

Parent/Guardian Authorization

<input checked="" type="checkbox"/> I understand that according to Aurora Board of Education Policy (Administering Medication) this form must be completed by the prescribing physician and parent prior to administration of prescription and non-prescription medication by designated school personnel. <input checked="" type="checkbox"/> I authorize a designated employee of the Aurora Board of Education to administer the above medication. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> I understand that additional parent/prescriber statements will be necessary if the dosage or time or interval of the medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order. <input checked="" type="checkbox"/> I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration. <input checked="" type="checkbox"/> I understand that a parent/guardian is required to drop off medication at the building clinic.			
Parent/Guardian Signature	Date	#1 contact phone	#2 contact phone