

## MEDICATION ORDER FORM

### Please return the completed form to the School Nurse

District policy requires consent of the parent/legal guardian and a written order from the licensed prescriber before medication can be given to a student by school personnel. All medications must be brought to school in their original containers with the affixed labels from the pharmacist. Prescription medication must display the student's name, the name of the medication, dosage directions, the licensed prescriber's name, and the Rx number (if applicable). A written order from the licensed prescriber is required for a student to carry emergency medication such as EpiPen, inhaler, seizure and Diabetes medication. The following information is necessary to comply with district policy. **All requested information and fields must be completed.**

TO BE COMPLETED BY A LICENSED PRESCRIBER (M.D, DO, NP, DMD, DDS, etc):					
<b>STUDENT NAME:</b>			<b>STUDENT BIRTH DATE:</b>		
<b>GRADE:</b>		<b>HOMEROOM:</b>		<b>TEACHER:</b>	
This student is under my care for (diagnosis) _____					
<b>Medication</b>	<b>Dosage</b>	<b>Time</b>	<b>Duration</b>	<b>Route</b>	<b>Side Effects to Notify Physician of</b>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Special Instructions: _____					
<b>Licensed Prescriber Signature:</b> _____				<b>Date:</b> _____	
<b>Licensed Prescriber Office Phone:</b> _____			<b>Licensed Prescriber Address:</b> _____		

AUTHORIZATION FOR STUDENT POSSESSION AND USE of EPINEPHRINE AUTOINJECTOR, INHALER, Emergency Seizure and Diabetes medication	
To be completed by students physician/Health Care Provider: _____ Date _____ <div style="text-align: center;">Licensed Prescriber signature</div>	
Student to Carry Medication? (Diabetes medication)	Yes _____ No _____ (Applies to <b>emergency medications only</b> - Epi-pens, inhalers, seizure and Diabetes medication)
Student to Self-Administer Medication? (and possible side effects of medication)	Yes _____ No _____ ("Yes" indicates student has been instructed in proper use, expected result)

TO BE COMPLETED BY THE PARENT / GUARDIAN:
I give permission for the principal or his/her designee to administer the medication as prescribed above to my child. I also agree to:
1. Notify the School Nurse if the medication or dosage is changed or held for that day. This must be verbally communicated to the School Nurse or Sub Nurse that day. If there is a change, a new order must be written. If alternate dosing is required (late arrival) or if stopped. (Note: If your child does not take a daily scheduled medication for more than 30 days, a new order from the doctor will be required.)
2. Grant permission for the school nurse to confer with the above physician/medical authority regarding the child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs
3. Provide safe transportation of the medication to and from school. Medication must be given directly to a school official.
4. If authorization to carry Epi-Pen is completed by the physician/medical authority, the parent <b>must</b> provide a backup dose of Epi-Pen (Ohio Revised Code 3313.718). Emergency medical services will be called if an Epi-Pen is administered.
5. If a physician has written an order for the student to carry emergency medication, the parent is requested to provide a backup for the School clinic.
<div style="display: flex; justify-content: space-around;"> <span>_____ Yes, I will provide a backup inhaler</span> <span>_____ No, I decline the need to provide a backup inhaler</span> </div>
<b>NOTE: Students may not transport medication unless the physician has completed a written order to carry an epinephrine autoinjector or inhaler</b>
<b>Parent Signature:</b> _____ <b>Date:</b> _____ <b>Phone:</b> _____

TO BE COMPLETED BY PRINCIPAL/ ASSISTANT PRINCIPAL:
<b>PRINCIPAL/ASSISTANT PRINCIPAL APPROVAL:</b> _____
<b>SIGNATURES OF PERSONS AUTHORIZED TO GIVE MEDICATION:</b> _____