**WELLINGTON EXEMPTED VILLAGE SCHOOL DISTRICT**
**305 UNION ST, WELLINGTON, OH 44090**
**440-647-4286 FAX 440-647-4806**
**FAX - WESTWOOD 440-647-1089 McCORMICK 440-647-7310 HIGH SCHOOL 440-647-7318**

**INSTRUCTIONS: PHYSICIAN AND PARENT MUST COMPLETE AND RETURN FORM TO SCHOOL BEFORE MEDICATION WILL BE ADMINISTERED; MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE ORIGINAL CONTAINER.**

| Student Name | Date of Birth | Age |
|---|---|---|
| Address | | |

| School (circle one) Westwood McCormick High School | Grade | Teacher | School year |
|---|---|---|---|

**PRESCRIBER AUTHORIZATION**

| Name of medication | Reason for medication to be given at school |
|---|---|
| Dosage | Route/Times to be given |
| Beginning Date | Ending Date |
| Special instructions | Refrigeration needed<br>Yes No |
| Adverse reactions/treatment | Next steps if desired effect not met (emergency medications only) |

EPINEPHRINE AUTOINJECTOR _____NOT APPLICABLE _____ Yes, as the prescriber I have determined that this student is capable of possessing and using this auto-injector appropriately and have provided the student with training in its proper use

Reminder ORC 3313.718 requires backup epinephrine auto-injector be provided at school

ASTHMA INHALER _____NOT APPLICABLE _____ Yes, as the prescriber I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in its proper use

| **PRESCRIBER SIGNATURE** | Date | Phone | Fax |
|---|---|---|---|
| Prescriber Name, Address (stamp) | | | |

**PARENT AUTHORIZATION**

I authorize an employee of the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if any medication changes occur. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify any discrepancies. I also understand that all medications must be transported to school by parent/guardian, it must be in the original container, properly labeled by dispenser with student's name, prescriber's name, name of medication, dosage, strength, time interval, route and expiration date. I understand that this is in compliance with ORC 3313.713.

**SELF CARRY AUTHORIZATION**

I authorize child to possess and use above prescribed medication:

[ ] epinephrine auto-injector. I also understand that a school employee will request assistance from an emergency service provider in the event that the medication is administered

[ ] asthma inhaler – the student has been instructed in its proper use

| **PARENT NAME (PRINT)** | | | |
|---|---|---|---|
| **PARENT SIGNATURE** | Date | #1 Contact Phone | #2 Contact Phone |