Hillsboro City Schools

Elementary: (937) 393-3132 Fax: (937) 393-2418
MS/HS: (937) 393-4421 Fax: (937) 393-3040

Medication Authorization Form

In accordance with ORC 3313.713

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: ______________________________ Date of Birth: ____________________

Parent Name: ______________________________ Grade/Teacher: ____________________

Address: ____

Home Phone: __________________________ Cell Phone: __________________________

I AGREE TO THE FOLLOWING:

1. I will assume responsibility for safe delivery of the medication to the school clinic by either by myself or by a responsible adult and for keeping record of the amount of medication at school so I can replenish the medication when needed.
2. I will deliver the medication only in its original pharmaceutical containers.
3. I will notify the school immediately if there is any change in the directions for use of the medication and will have a new authorization form completed for any changes.
4. I understand that any medication left in the building after the last day of school will be discarded.

I have read and understand the policy for administration of prescription medication and request that the above listed medication be administered by school personnel at school. Because school personnel are not legally obligated to administer medication to any student, I further acknowledge that by signing this form, I release all Board-designated school employees from any and all liability for damages, illness, or injury resulting from performing the assistance requested.

Signature of Parent/Guardian: ______________________________ Date: ________________

TO BE COMPLETED BY LICENSED PRESCRIBER

*If possible, the medication should be scheduled so the student does not have to take medication at school.

The above-named student is under my care and should receive the following:

____

Medication Dose Route Time

Reason for medication: ____

Specific instructions (duration, storage, etc.): ____________________________________

Possible reactions that should be reported: ____

Beginning date of this request: ____________________ Expiration date: ____________________

Printed name of licensed prescriber: ____

Signature of licensed prescriber: ________________________________ Date: ____________

Address: __________________________ Phone: ________________ Fax: ______________

TO BE COMPLETED BY THE SCHOOL

Signature of Nurse: ______________________________ Date: ________________________

Hillsboro City Schools

Elementary: (937) 393-3132 Fax: (937) 393-2418
MS/HS: (937) 393-4421 Fax: (937) 393-3040

Medication Authorization Form

In accordance with ORC 3313.713

Dear Parents/Guardians,

We strongly urge that all medications be administered at home whenever possible. Please consult the prescribing physician or nurse practitioner to see if the medications can be administered at times when your child is at home.

Before the school will give your child prescribed medication at school the State of Ohio law (Section 3313.713 O.R.C) requires that:

1. The parent must complete and sign the Medication Authorization Form.

2. The licensed prescriber must complete and sign the provider portion of the form.

3. The completed and signed form must be returned to school BEFORE the medication can be administered at school.

4. The medication must be brought to school, **by a parent or other responsible adult**, in the **original container** labeled with your child's name, the provider's name, the name of the medication, the dose and time it is to be taken. The instructions on the medication label must match the information given by the prescriber on the medication form.

5. Each medication must have a separate form.

6. Any changes in dosage will require new forms to be completed by the prescriber and parent before the new dosage can be given. A new prescription bottle with the correct label must be provided to the school.

7. If liquid medications are prescribed, the parent must provide an accurate measuring cup/spoon/syringe.

8. All medication must be kept in the clinic (except for asthma inhalers or auto injector epinephrine, provided appropriate forms have been completed and student requirements have been met).

These policies are for the health and safety of your child. If you have any questions, please contact the school nurse.