



Health forms for students taking **Medications at School**

Please complete packet and return to the nurse at your child's school.

What is in this packet?

- 1) Release of Information allows the doctor to talk to the school nurse if there are any questions
- 2) Guidelines for Medicines at School – parent reference
- 3) Medication Authorization - must be signed by parent and doctor and brought to school with the medication in the original bottle/container. One Medication Authorization form per medication. Medicine cannot be at school without signatures of both the doctor and parent.

Questions - Please call your school nurse.



Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**
- **Medications cannot be at school without the form and signatures of both doctor and parents. Medications cannot be held until the medication authorization form arrives.**
- **A new Medication Authorization Form is required each school year AND when there is a change in medication or dose.**
- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy and be labeled with the correct dose and instructions. The medication cannot be expired.**
 - The label must match what is on the Medication Authorization Form.
 - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
 - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.
- **Medication must be brought to school by the parent or guardian. Bus drivers cannot be responsible for medications on the bus.**
- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form is required.**
 - Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, eye drops, ointments.)
 - Over the counter medications must be in the original container and not expired.
 - A label must be attached to the medication which includes: the student's name, name of medication, dosage, strength, route, time of administration and expiration date. Label must match the Medication Authorization Form.
- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school. The medication should be given before school, after school and at bedtime.**

All unused medication must be picked up by the parent/guardian on the last day of student attendance or it will be discarded.



AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

Student Full Name:		Birth Date:	
School Name:		School Phone:	
Requested by: Name, Title		School Fax:	

☐ Fax Info to School ☐ Email Info to: _____

In order to release any confidential information regarding your student, Columbus City Schools is required by law to have your written permission as this information is protected under the Family Educational Rights and Privacy Act (FERPA). Please sign this form to indicate the agencies or individuals that Columbus City Schools may receive information from or release information to regarding your student. Please keep a copy for your records. This signed authorization will be valid for one year from the date of your signature. If you wish to revoke this consent, please provide written notice to your student's school.

I understand the requested information below will be used by the Columbus City School staff for educational and health care planning and service delivery at school.

Provider Name and Address	Provider Fax #	Provider Phone #

Dates Range of Records Requested: From Date: _____ To Date: _____

☐ Medical Info/Records: **specified below** ☐ Psychological Information/Records ☐ Immunization Records
☐ TB Test Results/Records ☐ Speech and/or Hearing Evaluation ☐ School Health Records

Specific Information Requested for educational and health care planning and service delivery at school :

--

I understand any release of information pertaining to substance abuse, mental health or HIV related records will be done only if needed to better meet the educational and school health needs of the student named above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity. Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987).

Authorization for Redisclosure: Under federal law, CCS may not redisclose the information identified above to any other party without prior consent.

Parent/Guardian or Adult Student Signature

Date

Printed Name of Parent/Guardian or Adult Student



Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Columbus City Schools
Health, Family and Community Services
Columbus Ohio 43215

Student Name _____ Date of Birth _____ School Year _____

Home Address _____ School _____ HR/Grade _____

If multiple medications are needed at school, please contact your school nurse for the appropriate forms

Healthcare Provider to Complete:

Columbus City Schools urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of _____

Medication _____ Strength/Concentration _____ Dosage _____ Route _____

Administration Time(s) _____ OR ☐ Every _____ hours as needed for _____

Beginning Date _____ Expiration Date _____ or ☐ End of school year

Instructions: _____

Precautions and possible side effects _____

Other medications prescribed to this student (home & school) _____

Healthcare Provider Signature _____ Date _____

Provider Name _____

Practice Address _____

Phone _____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed.**
- A new Medication Authorization form is required each school year and when there is a change in the medication.
- I authorize the student named above to receive the medication as ordered above.
- I understand the medication must not be expired, be in the original container and labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Columbus City School Health Services staff to communicate with the student's healthcare provider as needed.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ Phone Number _____ Date _____

PLEASE return this form to _____, School Nurse

Email: _____@columbus.k12.oh.us Phone _____ Fax 614-365-_____