MIAMI VALLEY
CAREER TECHNOLOGY CENTER
6800 Hoke Road | Englewood, OH 45315
937-854-6261 | 937-837-1594 fax | www.mvctc.com

Authorization for Prescribed Medication/Drug or Treatment (Form 5330 F1)
To be completed by a licensed prescriber and parent/guardian

If a student must take prescription medication during school hours, a completed authorization form must be on file. Please note that trained non-medical school personnel may administer medication under the direction of the school nurse. For safety reasons, certain medications—such as those that cause drowsiness or dizziness—may not be permitted in the school or CTE setting. Contact the school nurse before submitting the form to discuss any concerns.

Student Information

Name: _____ MVCTC ID #: _____

Address: _____ City: _____ Zip: _____

Partner School: _____ Program: _____

Medication/Treatment Information (to be completed by prescriber)

Medication/Drug Name: _____

Dosage: _____ Route: _____

Time(s)/Intervals: _____Start Date: _____ End Date: _____

Adverse Reactions to Report:

_____

_____

_____

Special Instructions (incl. sterile conditions, storage):

_____

_____

_____

Prescriber Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Prescriber Signature: _____ Date: _____

Parent/Guardian Authorization

☐ I authorize MVCTC personnel to administer the above medication/treatment to my child.
☐ I give permission for direct contact between school personnel and the prescriber if needed.
☐ I understand this does not replace the Emergency Medical Authorization Form on file.
☐ I agree to deliver the medication in its original, properly labeled container and may be refused if not.
☐ I agree to deliver the medication directly to the school clinic.
☐ I understand a new form must be submitted if medication, dosage, schedule, or instructions change.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone #: _____ Email: _____

Return this form to the MVCTC School Nurse