AUTHORIZATION FOR MEDICATION: Prescription or Over-the-Counter Medication

***Student's Name:** ______________________________ ***Date of Birth:** ______________

*** Home Address:** ______________________________

***School:** ____________________ ***Grade:** __________ ***Class:** ____________________

School Phone #: ____________________ **School Fax#:** ____________________

Allergies: ______________________________

Diagnosis: ______________________________

*MEDICATION	*DOSAGE	*ROUTE	*FREQUENCY	*SPECIFIC TIMES	*SPECIAL INSTRUCTIONS/ SIDE EFFECTS

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, reactions, etc.) :

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***Prescriber's Name (Printed)**	***Prescriber's Signature**
***Prescriber's Telephone & Fax Numbers**	***Date of Administration to Begin**
Prescriber's Office Address	***Date of Administration to Cease**

PARENTAL PERMISSION FOR MEDICATION

(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: ____________________ **Date of Birth:** __________ **Grade:** __________

I grant the board, or person designated by the board, permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her prescriber to self-administer their medication for asthma care, diabetes care, or anaphylaxis, I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the board, or person designated by the board, to perform the administration of the medication.

NOTE:

- Medications must be supplied in the original container. Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.
- School personnel may administer only medications authorized by a prescriber.
- It is your responsibility to notify the school when there is a change in medication regimen.

Parent / Guardian Name (Printed)	Signature of Parent / Guardian
Date Signed	Best Number(s) to be reached

Information required by ORC 3313.713

AUTHORIZATION FOR TREATMENT

***Student's Name:** ______________________ ***Date of Birth:** ______________
*** Home Address:** ____
***School:** ____________________ ***Grade:**__________ ***Class:**____________________

School Phone #: ____________________ **School Fax#:** ____________________
Allergies: ____
Diagnosis: ____

TREATMENTS DURING SCHOOL HOURS

PROCEDURE	TYPE	MEDS / FEEDING AMOUNT	FREQUENCY SPECIFIC TIMES	RATE / FLOW
Catheterization				
Feedings	▢ G-Tube ▢ J-Tube ▢ NG-Tube ▢Special			
Suctioning	▢ Oropharynx			
	▢ Tracheostomy ▢ Deep ▢ Surface			
Tracheostomy	▢ Tube Replacement			
	▢ Care (Cleaning)			
CPT				
Oxygen /Misting				
Ventilator				
Nebulizer Tx				
Pulse Oximeter				

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, reactions, etc.) :

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***Prescriber's Name (Printed)** ______________________ ***Prescriber's Signature** ______________________

***Prescriber's Telephone & Fax Numbers** ______________________ ***Date of Administration to Begin** ______________________

Prescriber's Office Address ______________________ ***Date of Administration to Cease** ______________________

PARENTAL PERMISSION FOR MEDICATION

I grant the board, or person designated by the board, permission to assist or perform the administration of each treatment/procedure to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her provider to self-administer their treatment, I grant permission for my child to self-administer their treatment at school and when they are away from school property for official school events. In the event that my child is unable to self- administer their treatment, I give permission for the board, or person designated by the board, to perform the administration of the prescribed treatment. NOTE: school personnel may administer only treatments authorized by a physician. ***It is your responsibility to notify the school when there is a change in treatment regimen.***

Parent / Guardian Name (Printed) ______________________ Signature of Parent / Guardian ______________________

Date Signed ______________________ Best Number(s) to reach ______________________

Revised August 2021