Newark City Schools

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

***Student's Name: _____ *Date of Birth: _____**
***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.) : _____
_____

_____ _____
***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 Home Phone Number

_____
Work/Cell Phone Number (Include Ext. if any)

Information required by ORC 3313.713

Revised 9/2018

Revised 9/2018

AUTHORIZATION FOR TREATMENT

***Student's Name: _____ *Date of Birth: _____**
***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 limitations / precautionary measures that should be considered; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices / equipment: _____
List any emergency precautions/ health emergencies that should be anticipated for this student: _____
_____

_____ _____
***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 TREATMENT

(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 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 Home Phone Number Work/Cell Phone Number (Include Ext. if any)