ADMINISTERING PRESCRIPTION MEDICATION TO K-12 STUDENTS PERMISSION FORM

Prescriber and parent be sure to sign in shaded area. If the medication is self carry, please fill out appropriate areas.

Student Name:			Date of birth
Student address			Phone #
Coldwater Schools	Grade/Class	Teacher	School Year
List any known drug allergies/reactions		Height	Weight

PRESCRIBER AUTHORIZATION

Name of Medication:		
Dosage	Route	Time/Interval
Date to begin Medication:	Date to end Medication:	
Circumstances for use		
Special Instructions		
Treatment in the event of an adverse reaction		
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 A) To the student for whom it is prescribed (that should be reported to prescriber)		
B) To a student for whom it is not prescribed who receives a dose		

Other medication instructions:	Refrigerate?	Yes	No
Is the medication a controlled substance?		Yes	No

Procedure for school employees if the student is unable to administer the medication or if it does not produce the expected relief:

PERMISSION TO SELF CARRY **(Please X)**

Epinepherine Autoinjector		Not applicable
		Yes, as the Prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.
Asthma Inhaler		Not applicable
		Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.

Prescriber Signature **X**	Date	Phone
Prescriber Name (print)		Fax
Prescriber address		

PARENT GUARDIAN AUTHORIZATION

I authorize an employee of the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order.

PARENT/GUARDIAN SELF CARRY AUTHORIZATION *Please mark the appropriate medication.*

	Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event or program sponsored by or in which the student's school is a participant. **I understand that a school employee will immediately call 9-1-1** as required by law. I will provide a backup dose of the medication to the school principal or nurse as required by law.
	Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed at school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian Signature X	Date

Medication instructions: All medications MUST be stored in the original container with proper labeling. Medications are stored in a locked medication cabinet unless specified above.