AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL AND SELF-ADMINISTRATION
FOR PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS
In accordance with the Ohio Revised Code

This form must be completed and provided to the school for administration of prescription and over-the-counter medications. The form is valid only for the current school year.
The parent /guardian must provide the medication in the original container.
AT THE HIGH SCHOOL LEVEL, students with medications at school are responsible for notifying their teacher if the medication needs to be available on field trips.

This section must be completed in full by the physician. Do not leave any item blank.

Student name_____DOB_____
School_____Grade_____
Medication_____Strength supplied_____Dosage_____
Route_____
Administration time_____OR every_____hours as needed for the following symptoms_____
Diagnosis for condition medication is prescribed_____
Side Effects/Adverse Reactions_____
Procedures if medication does not produce expected relief_____
Adverse reaction for unauthorized user_____
Special instructions for administration for administration or storage_____
Start date_____Stop date_____

If the medication is an **Epipen**, should it be administered immediately after sting, even if no symptoms of reaction are present?_____911 will be called immediately after administration.
For emergency medications: This student may carry and self-administer the above medication?_____
If yes, as the prescriber, I have determined that this student is capable of possessing and using this medication appropriately and have provided the student with training in the proper use of the medication and associated devices.
Licensed prescriber's signature_____Date_____
Address and phone_____

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Parent/Guardian Consent

I request that medication be administered to my child according to the directions of the licensed prescriber. Medically untrained school personnel may administer the medication. I also authorize the exchange of information between the health care provider and the school regarding this medication order.

Signature_____Date_____
Phone Home_____Work Phone_____Other Phone_____
Home address_____

Student Agreement

Self-Administration: I accept responsibility for self-administering the above medication. I will not share the medication with others; I will keep the medication secured; I will tell a teacher if I need to use the medication and inform them if I do not obtain relief following self-administration of the medication.
Student Signature_____Date_____
Jr High and High School Students: I will inform the teacher in advance if the medication needs to be available on a field trip.
Signature_____Date_____