Prescription Medication Authorization

West Carrollton School District

Name of Student: _____ Date of Birth: _____

Address: _____ School: _____ Class:_____

Ohio law (ORC 3313.713) states school personnel are not legally obligated to administer medication. West Carrollton School District has adopted a policy authorizing **specific** school personnel to administer medications under the following conditions.

1. **The medication cannot be scheduled for other than school hours.**
2. If medication has a scheduled time, it may be given up to 30 minutes before or after scheduled time.
3. This form must be complete with parent/guardian and treating practitioner signatures.
4. Only an adult will bring medication to the clinic, in the original and current prescription container.
5. Medications will be stored in the clinic; medications not pickup at the end of school year will be discarded.
6. Any changes in medication orders will be submitted by a new Medication Authorization form.

Treating Practitioner Order:

- Name of medication: _____Method of administration_____.
- Dose: _____ Times to be given: _____.
- Purpose of medication: _____.
- Medication to be administered from: _____ to _____. (Not to exceed one school year).
- Possible side effects: _____.
- Plan for management of side effects: _____.

Treating Practitioner (signature): _____ Date:_____

Treating Practitioner (printed): _____ Phone: _____

I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. Parent signature gives permission for the nurse to contact the treating practitioner with questions about child's medical condition or medication needs.

Parent/Guardian signature: _____ Phone: _____ Date: _____

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Permission to Carry/Self Administer Emergency Asthma Medications OR Epinephrine Pens

1. By signing authorization to carry/self-administer medication, the treating practitioner and parent/guardian agree the student is capable of administering prescribed medication, and assume responsibility for ill effects resulting from self-administration, and understand the school is not responsible if another child gains possession of the emergency medication.
2. **Treating practitioner and parent/guardian signature indicate this student demonstrates ability to safely carry and self-administer the above listed emergency medication.**

Treating Practitioner signature: _____ Phone: _____Date: _____

Parent/Guardian signature: _____ Phone: _____ Date: _____