MAD RIVER LOCAL SCHOOLS

PARENT REQUEST & AUTHORIZATION TO ADMINISTER MEDICATION (Prescribed or Over-the-Counter)

Student Name: _____ Address: _____

School: _____ Grade: _____ Teacher: _____

Name of Medication _____ Dosage _____Time(s)_____

PART I

TO THE PARENT/GUARDIAN: Students needing medication are encouraged to receive the medication at home whenever possible. The following information is necessary for any student who must take medication in school. All prescribed and over-the-counter medication must be accompanied by both Parent/Guardian and Licensed Prescriber authorizations.

By signing the form, the parent/guardian agrees to the following:

I will assume responsibility for the safe delivery of the medication to school in a properly labeled container: Prescription medication will be in a prescriber/licensed pharmacist-labeled container that includes the student's name, name of the medication, date, and dosage instructions (quantity and time) and prescriber's name. Over-the-counter medication will be in its original container with all labeling visible.

I will submit a new medication authorization form for each medication with parent and prescriber signatures at the beginning of each school year, and if the previous order changes during the school year.

For students transferring from other school districts: I understand that new medication authorization forms must be written by my licensed provider for MRLS. (Orders written for other school districts are not accepted.)

I release and agree to hold the Board of Education of MRLS, 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.

I authorize my child to receive the prescribed medication. I also authorize the exchange of information between the medication's Licensed Prescriber and the school regarding the health care needs of my child when deemed necessary by school personnel. I understand the School Nurse cannot provide or delegate the assistance with administration of this medication without this permission as determined by the Ohio Nurse Practice Act.

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Phone Numbers

WHEN AN EPI-PEN* IS PRESCRIBED, I understand I must provide <u>TWO</u> for use at school as required by Ohio law. (ORC 3313.718)

The school has been provided a back-up dose of the *Epinephrine Auto-Injector

Please initial: **YES**_____ / Date _____ **Expiration Date of Medication** _____ (Note on your home calendar)

PERMISSION TO CARRY <u>ASTHMA INHALERS*</u> & <u>EPI-PEN TYPE AUTO-INJECTORS*</u>

PART II

NOTE: The Licensed Prescriber must complete the "Permission to Carry" section of the Medication Authorization on the reverse side of this form. All requested information must be provided before we are able to permit your child to carry their emergency medication.

My child has permission to carry and self administer this medication.

I understand that students who are authorized to self-administer must carry their medication* on their person. I also understand that any irresponsible actions regarding the "self-administration of medications" will be subject to disciplinary action.

Signature of Parent/Guardian: _____ Date: _____

MAD RIVER LOCAL SCHOOL DISTRICT

PHYSICIAN / LICENSED PRESCRIBER MEDICATION AUTHORIZATION (Prescribed or Over-the-Counter)

PRESCRIBER: The MRLS Board of Education urges you to schedule medication administration times outside of school hours, whenever possible. When necessary, medication administration will be permitted, insofar as feasible, during the school hours.

Part I **MEDICATION ORDER BY LICENSED PRESCRIBER**

(One medication per sheet)

Name of Student: _____ DOB: _____

Medication _____ Dosage _____ Time (s) _____ Route_____

Beginning date: _____ End date: _____ Today's Date: _____

Special Instructions:

_____

Possible adverse reactions for the student the medication was prescribed (that should be reported to the prescriber):

_____

Possible adverse reactions for unauthorized user:_____

Procedure for MRLS employees if the expected relief is not produced or student is unable to administer the medicine:

_____

Prescriber's Signature: _____ **Office #:_____ Fax #: _____**

Prescriber's address: _____ **Emergency #:** _____

ASTHMA INHALERS & EMERGENCY AUTO-INJECTORS:

Part II **PERMISSION TO CARRY** **ASTHMA INHALER**

This student is capable of possessing and using the inhaler: YES** _____ NO _____ (if NO, inhaler will be kept in the clinic.)

This student has been trained on the proper use of the inhaler: YES** _____ NO _____ (if NO, inhaler will be kept in the clinic.)

**If the prescriber or school nurse determines the student to be incapable of possession or self-administration, the auto-injector will be stored and administered as deemed appropriate by school officials and outlined in the student's Emergency Action Plan.

PRESCRIBER SIGNATURE: _____ DATE: _____

Part III **PERMISSION TO CARRY** **EPINEPHRINE AUTO-INJECTOR**

NOTE: SCHOOL PERSONNEL WILL CALL 911 WHEN AN EPINEPHRINE AUTO-INJECTOR IS ADMINISTERED.

Allergen and/or Circumstances for use of the auto-injector:_____

This student is capable of possessing and using the auto-injector: YES** _____ NO _____

This student has been trained on the proper use of the auto-injector: YES** _____ NO _____

I understand I must prescribe two auto-injectors for use at school as required by ORC 3313.718: YES_____

**If the prescriber or school nurse determines the student to be incapable of possession or self-administration, the auto-injector will be stored and administered as deemed appropriate by school officials and outlined in the student's Emergency Action Plan.

PRESCRIBER SIGNATURE: _____ DATE: _____

Part IV **TO BE COMPLETED BY THE SCHOOL**

Date Received:_____ Signature of Administrator:_____

Person(s) authorized to give medication for this student: Principal, Secretary, Staff Member(s)_____

Signature of School Nurse:_____DATE: _____