HILLIARD CITY SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM - C
PRESCRIBER AUTHORIZATION

PURPOSE: Completion of this form is necessary to comply with the Ohio Revised Code 3313.713 & 3313.718 and Hilliard Board of Education policy.

INJECTABLE MEDICATION

Name of Student: ____ DOB: _________________

Medication: _____________________________________ Dosage: ___________________________

Route: ________________________________ Time: ______________________________________

FOR TREATMENT OF:

__ Medical diagnosis of: ____

__ STING ALLERGY - Specify insect if known: ______________________________________

__ FOOD/SUBSTANCE ALLERGY - Child may have an anaphylactic reaction to: __________

____

Circumstances under which this medication should be administered: ____________________________
____

NOTE: SCHOOL PERSONNEL WILL CALL 911 WHEN AN EPIPEN IS ADMINISTERED.

Any additional emergency follow up: ____

Is student able to self-carry and self-administer auto-injector? ____ YES* ___NO**

* By checking "yes" above, I acknowledge that I have deemed the student capable of possession and self-administration of the auto-injector and have provided them with appropriate training. I also understand that I must prescribe at least two injectors for use at school, as required by ORC 3313.718.

** 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 as such in the student's Emergency Care Plan.

Instructions to be followed in the event the student is unable to self-administer and/or the medication does not produce the desired result: ____
____

Possible side effects of medication: ____

Beginning date: ______________ Expiration date: ______________ Today's date: _____________

PRESCRIBER'S SIGNATURE: _____________________________ Phone Number: _____________

NPI#___________________________ Approved Ohio ORP provider: Yes/ No

PRESCRIBER'S address/office stamp: ____