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: _______________________________

HILLIARD CITY SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM - A
PARENT/GUARDIAN AUTHORIZATION

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

Student Name: ____________________ Address: ____________________ DOB: _______

School: ________________________ Teacher: ____________________ GRADE: _____

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 consumes medication in school. Over the counter medication must be accompanied by both licensed prescriber and parent authorization for students in grades K - 6. By signing this form, the parent/guardian agrees to the following:

1. I am requesting permission for the student named above to receive and consume medication as specified on the physician authorization form.
2. I assume full responsibility for safe delivery of medication to the appropriate school personnel.
3. I assume full responsibility for record keeping of the amount of medication at school and for replenishing the medication when needed.
4. I authorize Hilliard City Schools personnel to communicate with my health care provider as necessary concerning the use of this medication.
5. I will deliver medication only in its original or pharmaceutical container that is labeled by the pharmacy with the proper name and dosage.
6. I will notify the school immediately if there is any change in the use of medication.
7. I understand that it is my child's responsibility to come to the office to receive the medication.
8. I understand that no person who is authorized by the Board of Education to administer medication will be liable for administering or failing to administer the medication unless such person acts in a manner constituting negligence or wanton or reckless misconduct.
9. I understand that all medication remaining at school after the last day of school will be discarded.
10. I am responsible for knowing the information with regard to medication administration in my child's student handbook.

Name of medication ____________________ Dosage__________ Frequency___________

Signature of Parent/Guardian: ________________________________ Date: ___________

Home phone: _____________ Work phone: ______________ Pager/Cellular: ___________

PART II: Pertains ONLY to Inhalers and Epinephrine Auto-Injectors

My child has permission to carry and self- administer this medication. **NOTE: An authorization form signed by the licensed prescriber must accompany all inhaler and Epinephrine requests for grades K - 12. State law requires the parent/guardian to supply the school with a back-up auto-injector, in addition to the injector being carried by the student.**

Signature of Parent/Guardian: ______________________________ Date: ___________

PART III: Grades 7-12 ONLY: Non-prescription medication (over the counter) authorization
Name of medication ________________Dosage _________ Frequency____________

Note: The student may only carry a one-day supply of medication on his/her person. No such medication shall be given to another student. School personnel will not be responsible for administration or supervision of self- administered medication.

Signature of Parent/Guardian: ________________________________ Date: ___________