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: _____

HILLIARD CITY SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM - B
LICENSED PRESCRIBER AUTHORIZATION

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

TO THE PRESCRIBER: The Hilliard Board of Education urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the receiving and consumption of medications will be permitted, insofar as feasible, during school hours.

ORAL/MISCELLANEOUS MEDICATION

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Route: _____ Time: _____

Possible side effects to be reported to physician: _____

Special instructions: _____

Beginning date: _____ Expiration date: _____ Today's date: _____

PRESCRIBER'S SIGNATURE: _____ Phone Number: _____

NPI# _____ Approved Ohio ORP Provider: Yes / No

Prescriber's address/office stamp: _____

INHALED MEDICATION

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Route: _____ Time: _____

CHILD HAS PERMISSION TO CARRY AND SELF ADMINISTER: _____ YES _____ NO
(If NO, inhaler will be kept in school clinic/nurse's office.)

Possible side effects to be reported to physician: _____

Special instructions in the event that medication does not provide relief from asthma attack:
_____

Possible adverse reactions for unauthorized user: _____

Beginning date: _____ Expiration date: _____ Today's date: _____

PRESCRIBER'S SIGNATURE: _____ Phone Number: _____

NPI # _____ Approved Ohio ORP Provider: Yes / No

Prescriber's address/office stamp: _____

Revised 04/16