

St. Helen School
MEDICATION AUTHORIZATION FORM - A
PARENT/GUARDIAN AUTHORIZATION

Completion of this form is necessary to comply with the Ohio Revised Code 3317.713

Student Name: _____ Address: _____
School: ST. HELEN SCHOOL Grade: _____ Room: _____ DOB: _____

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. Both Parent/Guardian and Physician/Licensed Prescriber authorization must accompany all prescribed and over-the-counter medication.

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

- I am requesting permission for the student named above to receive the medication as specified on the medication order from the Licensed Prescriber. (Form B)
- I understand it is my responsibility to ensure that the Licensed Prescriber's section is completed properly.
- I understand that all prescription and over-the-counter medications need a completed medication authorization form for each medication.
- I assume full responsibility for safe delivery of medication to the appropriate school personnel.
- I will bring all medication to school in a properly labeled container - Prescription medication will be in a pharmacy-labeled container that includes the student's name, name of the medication, and physician's name, date, and dosage instructions (quantity and time). Over-the-counter medication will be in its original container with all labeling visible.
- I understand the school will accept medication in a pill/unit-dose form and that schools will not assume the responsibility for administering injections, liquid medications, including eardrops and eye drops, applying ointments, changing dressings, or splitting pills.
- I assume full responsibility for keeping track of the amount of medication at school and for replenishing the medication when needed.
- I will submit a new medication authorization form with parent and physician signatures if the previously provided information changes. I understand a new pharmacy-labeled container is also needed.
- I understand a new medication form must be submitted each school year.
- I understand it is my child's responsibility for requesting medication.
- I agree to pick up any remaining medication when discontinued or at the end of the year. I understand that any medication that has not been picked up by parent/guardian will be discarded.
- I release St. Helen School and the assisting employees of St. Helen School from liability arising from the assistance in the administration of that medication.

I 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 assistance with the administration of any medication to my child 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

*Name of Medication _____ Dosage _____ Time(s) _____

**Fill in if parent must sign form without the prescriber's order attached.*

PART II: Pertains ONLY to Asthma Inhalers and Epi-pen Auto-injectors

NOTE: The Licensed Prescriber must complete the "Permission to Carry" section of the Medication Authorization form that applies to Asthma medication or Epi-pen auto-injectors. 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. [*Asthma medication or Epinephrine (Epi-pen)]. I also understand that any irresponsible actions regarding the "self-administration of medications" will be subject to disciplinary action. **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: _____

St. Helen School
MEDICATION AUTHORIZATION FORM - B
PHYSICIAN / LICENSED PRESCRIBER AUTHORIZATION

Completion of this form is necessary to comply with the Ohio Revised Code 3313.716/3313.14

TO THE PRESCRIBER: St. Helen School urges you to schedule medication administration times outside of the school hours, whenever possible. When necessary, medication administration will be permitted, insofar as feasible, during the school hours.

Part I: MEDICATION ORDER
(See below for PERMISSION TO CARRY statements if prescribing Inhaler or Epi-pen)
Name of Student: _____ DOB: _____
Medication and 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 St. Helen School employees if the expected relief is not produced or student is unable to administer the medicine* Prescriber's Signature: _____ Emergency Number: _____
Prescriber's address: _____

** Information required when Asthma Inhaler or Epi-pen auto-injector prescribed*

Part II: PERMISSION TO CARRY: Asthma Inhaler
CHILD HAS PERMISSION TO CARRY AND SELF ADMINISTER _____ YES _____ NO (if NO, inhaler will be kept in the clinic.)
Child has been trained in the use and responsibilities of self-administration: _____ YES _____ NO (if NO, inhaler will be kept in the clinic.)
PRESCRIBER SIGNATURE: _____ DATE: _____

Part III: PERMISSION TO CARRY: Emergency Auto-Injectable Medication (Epi-pen)
NOTE: SCHOOL PERSONNEL WILL CALL 911 WHEN AN EPIPEN IS ADMINISTERED.
Circumstances for use of the auto-injector: _____
Is this student able to carry and self-administer auto-injector? _____ YES* _____ NO**
**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.
* 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 him/her with proper training. I also understand that I must prescribe at least two injectors for use at school, as required by ORC 3313.718
PRESCRIBER SIGNATURE: _____ DATE: _____

Part IV: TO BE COMPLETED BY THE SCHOOL
Parent completed Form A
Date Received: _____ Signature of Administrator: _____
Persons(s) authorized to give medication for this student: _____
Signature of School Nurse: _____ Date: _____