General Medication Authorization Form

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Student Information

Student Name: ____ Birthday: _______________

Address: ____

Parent/Guardian Phone Number: ___________________________ Phone #2: ___________________

Grade: ________ Teacher: ____ School Year: ________

Drug Allergies and Reaction: ____

Prescriber Authorization

Medication Name: ____ Dose: ________________

Route: _________ Frequency: _________________________ Diagnosis: _______________________

Special Instructions: ____

Epinephrine Autoinjector

☐ Not Applicable

☐ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Asthma Inhaler

☐ Not Applicable

☐ Yes, if the conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school.

Prescriber Signature: ____ Date: ________________

Prescriber Name (Print): ____ Phone: ______________

Parent/Guardian Authorization

By signing below, I authorize an employee of the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. Medication form must be received by the principal, his/her designee, and/or the school nurse. I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian Signature: ____ Date: ______________

☐ For epinephrine autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epi pen as prescribed at the school. I understand that a school employee will immediately request assistance from an emergency medical provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

☐ For asthma inhaler: As parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed at the school.

Parent/Guardian Signature: _______________________________________ Date: _________________

Adapted from HEA 7758 5/11 form from the Ohio Department of Health School Nursing Program. JB 9/2020