FORT FRYE LOCAL SCHOOL DISTRICT

SCHOOL MEDICATION AUTHORIZATION FORM

Name of Child: _____ Date of Birth: _____

School Attending: _____ Phone: _____

Ohio ORC 5123.42 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school or maintain or improve the potential for education and learning.

Medication must be in the original container. No medication (including over-the-counter medication and supplements) will be given at school without a current "School Medication Authorization Form" completed by an Ohio licensed physician.

PHYSICIAN'S ORDER *(To be completed by health care provider)* Only one medication per form

Name of medication / strength of tablet, capsule or liquid:

_____

Dosage: _____ How often? _____

Time to be given at school: _____ Route to be given: _____

Reason for medication / diagnosis: _____

_____

Possible side effects: _____

- ☐ Student has been instructed by physician in self-administration of **Epi-Pen** and is competent to safely self-administer
- ☐ Student has been instructed by physician in self-administration of **inhaler** and is competent to safely self-administer

For PRN medication only, please list specific symptoms that would necessitate administration of the PRN med:

_____

Regarding the PRN medication, please give instruction for when a medical referral is to be made:

_____

It is necessary for this medication to be taken during the school day at the time(s) indicated above.

_____ _____

Print Name of Licensed Physician Signature of Licensed Physician

_____ _____ _____

Address Phone and Fax # Date

****

TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, _____, be assisted in taking the above prescribed medications at school by authorized persons. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in health care provider.

I authorize exchange of information between my child's Physician, District Nurse, or site administrator with regard to this medication request.

_____ _____ _____/_____

Parent/Guardian Signature Date Phone #(home) / Emergency #

Form must be renewed every 12 months or whenever the prescription changes.

Revised 3/2015