Valley View Local Schools Health Services Prescription Medication Authorization

In accordance with Ohio Revised Code 3313.713. A new permit is required every year.

THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student _____ Date of Birth _____

Student's Address _____

School _____ Grade _____ Homeroom _____

A. I am requesting permission for my child named above to: (*Check all that apply*)

_____ Receive medication from an authorized Staff member. In accordance with the authorized prescription written below.

_____ Carry & self-administer an asthma inhaler and/or Epinephrine auto-injector in accordance with the authorized prescription below.

_____ Receive prescribed treatment in accordance with the authorized prescription below.

B. I will assume responsibility for safe delivery of the medication/drug to school. Medication may not be sent to school in the student's lunch box, pocket, backpack or any other means on or about his/her person. The medication/drug must be received by the District (ie. The person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or pharmacist or in its original over the counter container.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. I understand a new school medication permit must be completed and submitted to school each time changes are made to the prescription or treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from all liability foreseeable, unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

If the the licensed provider authorizeS the student to carry and self-administer an asthma inhaler or an epinephrine auto-injector:

- Parent/Guardian will provide a backup dose of medication (Epinephrine) to the school principal or nurse as required by law.
- It is strongly recommended that Parent/Guardian provide a second inhaler to be stored in the clinic in the event the student does not have his/her inhaler.
- The student should be responsible for reporting the use of the inhaler to the nurse and/or principal.
- The parent/guardian must sign and date the Carry/self-administer box below and the licensed prescriber must check the Carry/Self-administer Authorization.

Parent/Guardian Signature _____ Date_____

Phone during school day _____ Other phone _____ mobile _____

Parent/Guardian Authorization for child to Carry/Self-Administer an Epinephrine Auto-Injector or Asthma Inhaler.

- For Epinephrine auto-injector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that the school employee will immediately request assistance from an emergency medical provider if this medication is administered.
- For Asthma Inhaler: As the parent/guardian of the student, I authorize my child to possess and use asthma inhaler as prescribed, at the school or any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian Signature _____ Date _____

THIS SECTION TO BE COMPLETED BY A LICENSED PRESCRIBER

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above-named student.

Medication _____ Date of Authorization _____

Dosage _____ Time(s) to be given _____ Start Date _____ End Date _____

AUTHORIZATION FOR CHILD TO CARRY/SELF-ADMINISTER AN ASTHMA INHALER OR EPINEPHRINE AUTO-INJECTOR AS PRESCRIBED

Adverse reactions to be reported_____

Diagnosis _____

Licensed prescriber emergency telephone _____Alternate telephone _____

Special Instructions _____

Administration _____

Storage _____

Other _____

Prescriber name (print) _____ Signature _____

FOR SCHOOL USE ONLY

The following school personnel have read this forma and are authorized to administer the medications as outlined

Nurse's Signature _____ *Date* _____

Signature _____ *Date* _____

Signature _____ *Date* _____