

**Permit for Administering Prescription Medication
(in accordance with Ohio Revised Code 3313.713)**

The use of medication during school hours is discouraged. Use this form if it is essential for a student to receive medication during the school day.

This section is to be completed by the parent or guardian

Name of Student _____ Birthdate _____

Student's Address _____

School _____ Grade _____ Home Room _____

I request school personnel to administer the medication as instructed and agree to notify the school if I change physicians or if the medication is changed or eliminated. I will deliver the medication to the school in the original container and understand the **medications are not to be transported by my child**. I understand that it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility for the results of such medication.

Parent/Guardian Signature _____ Date _____

Telephone during school hours _____ Other telephone _____

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN

Complete reverse side of student is to carry:

Medication _____ and self-administer asthma inhaler.

Date of Authorization _____ Dosage _____

Time(s) to be given _____

Date to begin _____ Date to end _____

Adverse Reactions to be Reported _____

Physician Emergency Telephone _____ Alternate Telephone _____

Special Instructions:

Administration _____

Storage _____

Other _____

Manual Signature Required (No Stamps)

Prescribing Physician (print) _____ Signature _____

Physician's Address _____

For School Use Only

The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature _____ Date _____

Signature _____ Date _____

Self-Medication for Asthma Inhalers

Authorization Form

Student Name: _____ Date _____

Address: _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reactions that should be reported to the physician: _____

Adverse reactions for unauthorized user: _____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack: _____

Other special instructions: _____

Physician and parent/guardian names, signatures and emergency phone numbers:

Physician Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: (work) _____

(home) _____

(other) _____

Signature: _____ Date: _____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.

Compliments of the Ohio Association of School Nurses, P.O. Box 162, Worthington, OH 43085