CATHOLIC DIOCESE OF YOUNGSTOWN
Office of Catholic Schools

School Medication Administration Authorization Form

Student's Name: _____ DOB: _____

Grade: _____ Teacher: _____ School Year: _____

This form must be completed fully, in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of medication administration.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original packaging with the label intact and student's name.
- A parent/guardian **must** bring the medication to school. Students **are not** permitted to bring medication to school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or child's medication.

♦PRESCRIBER'S AUTHORIZATION♦

(this section must be completed by the prescriber)

Condition for which medication is being administered: _____

Medication name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: □ None expected □ Specify: _____

Special Instructions: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____
(Original signature or signature stamp ONLY)

Date: _____

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school nurse, _____ for the above medication on _____
or designated personnel (name) (date)

_____
Signature

♦PARENT/GUARDIAN AUTHORIZATION♦

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication; otherwise it will be properly discarded. I/We authorize the school nurse to communicate with the health care provider or prescriber as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, 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 a school employee will immediately request assistance from an emergency medical service 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.

Parent /Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

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.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07

CATHOLIC DIOCESE OF YOUNGSTOWN
Office of Catholic Schools

EMERGENCY MEDICAL AUTHORIZATION

Student: _____ Grade and Room: _____
Address: _____ Home Phone: _____
Mothers' Name: _____ Work Phone: _____ Cell Phone: _____
Fathers' Name: _____ Work Phone: _____ Cell Phone: _____

Alternate Persons to Contact: (People to contact if your child is ill and neither parent can be reached.)
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medical condition which the school or an emergency physician should know. _____
_____
_____
_____

Public School District of Residence: _____ Public School child would attend _____

Purpose: To enable parents or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

I hereby give consent for the following medical care providers and local hospital to be called:
Doctor_____ Daytime Phone_____
Dentist_____ Daytime Phone_____
Medical Specialist_____ Daytime Phone_____
Local Hospital_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.
Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:
_____

Signature_____ Date_____

****

Refusal to Consent
I do NOT GIVE my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____
_____

Signature_____ Date_____

Ohio Department of Health

Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716/3313.14

A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent /Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Procedures for school employees if the medication does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the physician)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

Physician signature	Date
Physician name	Physician emergency telephone number ( )

Adapted from the Ohio Association of School Nurses