



### Authorization to Dispense Prescription and Nonprescription

*Over the Counter medication can be approved by parents signature.*

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_

Route \_\_\_\_\_ Time \_\_\_\_\_ Duration \_\_\_\_\_

Reason for Medication/Treatment \_\_\_\_\_

**Prescription** ☒

**Over the Counter** ☐

Special Instructions \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

*This student received instruction in the use of the above inhaler by my trained staff or me. I recommend that this student carry his/her inhaler on his/her person at all times. **Yes No***

*This student received instruction in the use of the above Epinephrine Device by my trained staff or me. I recommend that this student carry his/her Epinephrine device on his/her person at all times. **Yes No***

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby request and give permission to the nurse, principal, or the principal's designee to administer the prescribed medication listed above to my child as instructed by the physician or authorized healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects. If applicable, my child may carry his/her inhaler or Epinephrine device as prescribed by physician on his/her person during school or school-related activities as stated above. My child and I are aware of the protocols and safety issues at school.

All medication must be clearly labeled and brought to the school (by Parent/ Guardian) in the original container as dispensed by the authorized healthcare provider, physician, or pharmacist. Ask the pharmacist to give you two containers if necessary. Send only the amount of medication that will be administered during school hours or school-sponsored activities. Medications will be kept in the school clinic/office or other secure storage area. New forms must be submitted each school year for any medication dispensed at school.

If any revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the nurse, principal, or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless she/he is physically or mentally unable to do so. I release and agree to hold the school and its designees harmless from any all liability or injury resulting directly/indirectly from this authorization. Refer to Ohio Revised Code (ORC) 4729.01 & 3313.713

Parent/Guardian Signature \_\_\_\_\_ Phone \_\_\_\_\_

