

MCNICHOLAS HIGH SCHOOL

REQUEST FOR THE ADMINISTRATION OF MEDICATION

BY SCHOOL PERSONNEL: PHYSICIAN

Name of Student _____ Address _____ Grade _____

The above named student is under my care and should receive the following medication:

_____ at the following times(s) _____
Name of Drug, Dosage, Route _____

Specific instructions for administration _____

Possible side effects to watch for _____

Side effects to report to the doctor _____

Starting date of this request _____

Expiration date of this request _____

Date _____

Physician's Signature

Physician's Phone Number

REQUEST FOR THE ADMINISTRATION OF MEDICATION

BY SCHOOL PERSONNEL: PARENT

I hereby request and give my permission to the principal or his delegate (school nurse or other responsible person) to administer the following medication to my child.

Name of Child _____

Name of Drug _____ Dosage _____ Route _____

at the following time(s) _____

Date _____

Signature of Parent or Guardian

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.

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 ()