CHARDON LOCAL SCHOOLS
MEDICATION PERMISSION FORM

Student Name:____ Grade/Class _______ Teacher:_______________________ School _____________________
Student Address:____ Date of Birth______________________________

<u>TO BE COMPLETED BY HEALTH CARE PROVIDER</u> *Please print clearly and complete **ALL sections.***

Name of Medication	Dose	Route (circle)	Time/Frequency (Include minimum time Interval for prn dosing)	Reason for Medication	Start Date	Stop Date	Adverse Reaction to Report to Physician and/or Special Instructions
		Tablet/Capsule PO Liquid PO Inhaler/Nebulizer Other__________	_________________ **OR** As needed every __hrs.		__/__/__	___/___/___ **OR** ___ End of School year	
		Tablet/Capsule PO Liquid PO Inhaler/Nebulizer Other__________	_________________ **OR** As needed every __hrs		__/__/__	___/___/___ **OR** ___ End of School year	

EPINEPHRINE AUTOINJECTOR SELF-CARRY AUTHORIZATION	☐ **Not Applicable** ☐ **Yes, 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.**
ASTHMA INHALER SELF-CARRY AUTHORIZATION	☐ **Not Applicable** ☐ **Yes, as the prescriber I have determined that this student to capable of possessing and using this inhaler appropriately and have provided the student with training in the proper use of the inhaler.**

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler

Health Care Provider Name ____ Health Care Provider Signature: ____
Date_________________ Phone Number: ____ Fax Number: ____

<u>TO BE COMPLETED BY PARENT OR GUARDIAN</u>

☒ **I** authorize an employee of the school board to administer the above medication. ☒ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☒ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. ☒ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☒ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

CHECK BELOW ONLY IF PHYSICIAN HAS GIVEN AUTHORIZATION TO SELF-CARRY EPINEPHRINE AUTOINJECTOR OR INHALER.

☐ *For Epinephrine Autoinjector: 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.*

☐ *For Asthma inhaler: 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 Name________________________Parent/Guardian Signature__________________________Date________Phone___________________