School Year:_____ Grade/Teacher:_____

HERITAGE CHRISTIAN SCHOOL

PRESCRIPTION MEDICATION FORM

Student Information

Student Name: _____ Date of Birth:_____

Student Address: _____

List any known drug allergies:_____

Prescriber Authorization

Name of medication:		Dosage:	
Time to be given:	Route:	Reason for medication:	
Start Date:		Stop Date:	
Special Instructions		Potential Adverse Reactions	

Select one of the following:

- ☐ Not applicable for Self Carry Authorization for Epinephrine Autoinjector or Asthma inhaler.
- ☐ **Epinephrine Autoinjector:** 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.
  ***** Reminder, ORC 3313.718 requires backup epinephrine autoinjector be provided at school.**
- ☐ **Asthma Inhaler:** Yes, as the prescriber I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in its proper use.

Prescriber Name(Print):	Date	Phone	Fax
Prescriber Signature:			

Parent/Guardian Authorization

- ☑ 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 and forms must be received by the school nurse and/ or school office. 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.

Parent/Guardian Signature	**Date**	**#1 contact phone**	**#2 contact phone**

Parent/Guardian Self-Carry Authorization (only fill out if applicable)

Select the applicable choice:

- ☐ **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 understand it is my responsibility to provide a backup dose of medication to the school as required by law**.**
- ☐ **Asthma Inhaler:** As the parent/guardian of this student, I authorize my child to possess and use asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student is a participant.

The school will not be responsible for ensuring that the child has the medication with him/her or for accidental use of the medication

Parent/Guardian Signature	**Date:**

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School Year:_____ Grade/Teacher:_____

Medication Drop-Off and Pick-Up Instructions

Medication drop-off instructions

Parent/Guardian must drop off medication (or designate a responsible adult) to school. **Students may not transport medications or refills.**

The Ohio Revised Code and school district policy state that you must have:

- Written medication authorization record from your child's licensed health care prescriber and signed permission from the parent/guardian.
- Medication must be brought in its original container. Pharmacy-labeled original bottle with student name and prescription details/ number.

Medication pick-up instructions

If your child's medication is discontinued during or after the end of the school year, safe arrangements must be made for the medication to be returned home. Please indicate your choice of how you prefer us to handle the return of your child's medication once discontinued by the health care prescriber or at the end of the school year.

1. _____ I will come to the school office/clinic when my child's medication is discontinued by the health care prescriber or it is the end of the school year.
2. _____ I request that the school dispose of any medication remaining after the last day of school.

If medication is not picked up at the end of the school year, all medication will be discarded and will not be stored over summer.

Parent/Guardian Signature	**Date**

Please contact the school for any questions or concerns.

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