**Circleville City Schools**

## MEDICATION AUTHORIZATION FORM – A Page 1

PARENT/GUARDIAN AUTHORIZATION

Completion of this form is necessary to comply with the Ohio Revised Code 3317.713

Student Name:_____Address:_____

School: Circleville City Schools Grade:_____ Room:_____DOB:_____

**PART I: TO THE PARENT/GUARDIAN: Students needing medication are encouraged to receive the medication at home whenever possible. The following information is necessary for any student who must take medication in school. Both Parent/Guardian and Physician/Licensed Prescriber authorization must accompany all prescribed and over-the-counter medication.**

**By signing the form, the parent/guardian agrees to the following:**

- I am requesting permission for the student named above to receive the medication as specified on the medication order from the Licensed Prescriber. (Form B)
- I understand it is my responsibility to ensure that the Licensed Prescriber's section is completed properly.
- I understand that all prescription and over-the-counter medications need a completed medication authorization form for each medication.
- I assume full responsibility for safe delivery of medication to the appropriate school personnel.
- I will bring all medication to school in a properly labeled container - Prescription medication will be in a pharmacy-labeled container that includes the student's name, name of the medication, and physician's name, date, and dosage instructions (quantity and time). Over-the-counter medication will be in its original container with all labeling visible.
- I understand the school will accept medication in a pill/unit-dose form and that schools will not assume the responsibility for administering injections, eardrops, and eye drops, applying ointments, changing dressings, or splitting pills.
- I assume full responsibility for keeping track of the amount of medication at school and for replenishing the medication when needed.
- I will submit a new medication authorization form with parent and physician signatures of the previously provided information changes. I understand a new pharmacy-labeled container is also needed.
- I understand a new medication form must be submitted each school year.
- I understand it is my child's responsibility for requesting medication.
- I agree to pick up any remaining medication when discontinued or at the end of the year. I understand that any medication that has not been picked up by parent/guardian will be discarded.
- I release Circleville City Schools and the assisting employees of Circleville City Schools from liability arising from the assistance in the administration of that medication.

**I authorize the exchange of information between the medication's Licensed Prescriber and the school regarding the health care needs of my child when deemed necessary by school personnel. I understand the School Nurse cannot provide or delegate assistance with the administration of any medication to my child without this permission as determined by the Ohio Nurse Practice Act.**

Signature of Parent/Guardian:_____ Date:_____

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

**Emergency Phone Numbers:_____**

* Name of Medication _____ Dosage:_____ Time(s): _____

**** Fill in if parent must sign form without the prescriber's order attached.***

**PART II: Pertains <u>ONLY</u> to Asthma Inhalers and Epi-Pen Auto-injectors**

**NOTE: The Licensed Prescriber must complete the "Permission to Carry" section of the Medication Authorization form that applies to Asthma medication or Epi-pen auto-injectors. All requested information must be provided before we are able to carry their emergency medication.**

My child has permission to carry and self-administer this medication. I understand that students who are authorized to self-administer must carry their medication* on their person. {*Asthma medication or Epinephrine (Epi-pen)}. I also understand that any irresponsible actions regarding the "self-administration of medications" will be subject to disciplinary action. **<u>State law requires the parent/guardian to supply the school with a back-up auto-injector, in addition to their injector being carried by the student.</u>**

Signature of Parent/Guardian:_____ Date:_____

### *Two Hour Delay Policy*

Two hour delay days present unintended logistical hurdles in administering medication to students during the appropriate time windows designated by your child's physician. Circleville City Schools believes in working together with families to assure that students do not miss a dosage of medication despite the delayed start to your child's day. Please read over and initial below on the following two hour delay policies when it comes to medication administration at home and at school.

_____I understand that on days when there is a 2-hour delay, any morning medications will NOT be given at school and should be given at home prior to coming to school

_____I understand that lunch time medications will still be given on 2-hour delay days unless I call the school and request it not be given that day.

In the event you have any questions or need to discuss a change in your child's health plan while at school, please contact the school nurse at the contact information listed below.

Jaime McKeivier, BSN, R.N, LSN

School Nurse

Jaime.McKeivier@cvcsd.com

740-474-2495 ext. 49099

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Signature of Parent/Guardian:_____ Date:_____