AUTHORIZATION FOR PRESCRIBED AND/OR NONPRESCRIBED MEDICATION / DRUG OR TREATMENT FORM

(Including Asthma Inhaler and Epinephrine Autoinjector Use)

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED OR NONPRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL.

Student Information (This section is to be completed by the parent or guardian). **ALL SPACES MUST BE COMPLETED.**

Student Name				Date of Birth
Student Address			Parent Name	
Butler Tech Campus	School Year	Grade / Class	Parent / Guardian Email	Parent Phone Number
List any known drug allergies / reactions				

Prescriber Authorization (This section is to be completed by the physician).

Name of medication		Date of Authorization	
Dosage		Route	Time / Interval (To be given - noon, PRN, lunch)
Date to begin medication		Date to end medication	

Circumstances for use

Special Instructions

❑ Please check if applicable. For overnight field trips - May administer medication as prescribed

Treatment in the event of an adverse reaction

Epinephrine Autoinjector
- ❑ 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
- ❑ Not applicable
- ❑ Yes if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participate.

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 Reaction(s) per ORC 3317.716 and 3313.718

a) To the student for whom it is prescribed (that should be reported to the prescriber)

b) To a student for whom it is not prescribed who receives a dose

Other medication instructions

Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No

Prescriber signature	Practice Name	Phone	Fax

Prescriber name (print)

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

Parent/Guardian Authorization

I request school personnel to administer or observe the medication as instructed (including overnight field trips if applicable) and agree to deliver the medication to the school in the original container and notify the school in the event of a change in physician or medication.

I authorize the District School Nurse to talk with the prescriber or pharmacist to clarify the medication order.

I understand that it is the student's responsibility to report on time for this medication.

I understand that if the physician orders an emergency medication for self-administration that I should provide a second emergency medication to be stored in the student clinic (in the event the student forgets theirs) and that the student should report use of the emergency medication to the school nurse for assessment of effectiveness.

I agree to hold Butler Tech and its employees free from all responsibility for the administration of medication.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

As the parent/guardian of this student I authorize my child to possess and use an **(circle all that apply)** epinephrine autoinjector/albuterol inhaler, 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 epinephrine/glucagon/ seizure rescue is administered. I will provide a backup dose of the emergency medication to the school principal or nurse as required by law and give permission for designated school personnel to administer **(circle all that apply)** epinephrine/albuterol/glucagon/seizure rescue in the event that my child is incapable. I agree to hold Butler Tech and its employees free from all responsibility for the administration of medication.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

❑ File per district policy