Badin School
Phone: 863-3993
Fax: 785-2844

PERMIT FOR DISPENSING Over-The-Counter AND Prescription MEDICATION

In accordance with Ohio Revised Code 3313.713

THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student_____ Date of Birth _____
Student's Address _____
School _____ Grade _____

A. I am requesting permission for my child named above to: (Check all that apply)

_____ Receive prescribed medication / treatment

_____ Self-administer prescribed medication(s) in presence of an authorized staff member.

_____ Carry and self-administer Inhaler / Epinephrine / Diabetic treatment *

B. I will assume responsibility for the medication being delivered to the school office by an adult. The medication must be received in it's original over-the-counter or prescription container, labeled with the student's name.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. (You must submit to the school a written statement from the physician, signed by the prescriber, if any of the information contained in the statement changes.)

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable, unforeseeable for damages or injury resulting directly or indirectly from this authorization.

* <u>If the licensed provider authorizes that the student possess and use an asthma inhaler and/or an epinephrine auto-injector</u>:

- Parent/Guardian will provide a backup dose of the medication (Epinephrine) to the school principal or nurse as required by law.
- It is strongly recommended that parent/Guardian provide a second inhaler to be stored in the clinic in the event that the student does not have his/her inhaler.
- The student should be responsible to report use of inhaler to the nurse and/or principal.

Parent/Guardian Signature_____ Date_____

Phone during school _____ Other phone_____ Cell phone _____

THIS SECTION TO BE COMPLETED BY LICENSED PRESCRIBER

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student.

Medication _____ Date of Authorization _____

Dosage _____ Time(s) to be given _____ Start Date _____ End Date _____

Adverse reactions to be reported _____

Diagnosis _____

Licensed prescriber telephone _____ Fax _____

Special Instructions _____

Administration _____

Storage _____

_____(X) As the prescriber, I have determined *this student capable of possessing and using an Epinephrine* auto-injector - OR - *Inhaler* appropriately and have provided the student with training in the proper use of it.

Prescriber name (print) _____ **Signature** _____

Prescriber address / Practice name _____

FOR SCHOOL USE ONLY

The following school personnel have read this form and are authorized to administer the medication as outlined.

Nurse's Signature _____ Date _____

Principal's Signature _____ Date _____

*Copies must be provided to Principal and School Nurses assigned to the student's building. Teachers should be notified of student carrying Asthma Inhaler, Epinephrine Auto-injector and Diabetic supplies. 10/2017 ms