SAINT THOMAS MORE SCHOOL

# Medication Permission Form

*Complete and return this form to your school to provide parental authorization and physician's request for the administration of prescription and non-prescription drugs, herbs, supplements, and medication to a student by school personnel. If the student is authorized to carry an inhaler or Epi-Pen this form must also be completed and on file. A new, separate form should be submitted for each individual medication.*

Student Name _____ Date of Birth _____

Address _____ Phone _____

School _____ Grade _____ Teacher/Homeroom _____

## TO BE COMPLETED BY PHYSICIAN/DENTIST (ONE FORM PER MEDICATION)

Medication _____ Dose _____ Route _____ Time _____

Start Date _____ End Date _____ Diagnosis _____

Possible side effect or adverse reactions (notify prescriber) _____

Instructions for Administration, Storage, and Sterile Conditions _____

**Self-carry Epinephrine Auto Injector:** ☐ not applicable **OR** ☐ Yes, as the prescriber, I have determined that this student is capable of possessing and using this auto injector appropriately and have provided the student with training in the proper use of the auto injector.
**Self-carry Asthma Inhaler:** ☐ not applicable **OR** ☐ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or any activity, event, or program sponsored by or in which the student's school is a participant.
Procedures for school employees if the student is unable to administer the medication or 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 prescriber) _____

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

**Prescriber Name (Print)** _____ **Date** _____ **Phone** _____ **FAX #** _____

***Reminder note for prescriber: ORC3313.718 requires backup epinephrine auto injector and best practice recommends backup asthma inhaler.***

**Prescriber Address** _____ **Prescriber Signature** _____

## TO BE COMPLETED BY PARENTS/GUARDIANS

I/we understand and give my/our permission to the Principal or his/her delegate (school Health Aide or other responsible adult) to administer the medication as prescribed above to my child. In addition, I/we understand that:

1. District policy requires the consent of the parent/legal guardian and a written statement from the doctor/dentist accompanied by written permission from a parent before medication can be given to a student by school personnel.
2. Medication must come to school in the **original** container with the affixed label from the pharmacist containing 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. Non-prescription medication must be received in its original container.
3. All medication must be brought to the school by the parent/guardian of the student. Students are **NEVER t**o transport medication to school.
4. If an authorization to carry an epinephrine auto injector is indicated by the physician, I will provide a backup dose of the medication as required by Ohio law (Ohio Revised Code 3313.718) Emergency services will be called if Epi-Pen is administered. I authorize my child to possess and use and epinephrine auto injector, as prescribed, at the school and any activity, event, or program by or in which the student's school is a participant.
5. If an authorization to carry an asthma inhaler is indicated by the physician, 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.
6. I will notify the school by completing a revised form if the medication or dosage is changed or discontinued by prescribing physician/dentist.
7. In consideration for the St. Thomas More Parish School and its designated employees administering the prescribed medication to my/our son/daughter as I/we are unable to do so during school hours, I/we on behalf of ourselves and our heirs, administrators, executors, successors, assigns, and our child do hereby fully and forever release, acquit, and discharge the St. Thomas More Parish School/Church individually, and the employee(s) administering the prescribed medication from any and all liability, actions, causes of actions, claims and demands of whatever kind or nature that I/we may have on behalf of myself/ourselves and my/our named child on account of any and all injuries, losses, and damages which my/our named child may sustain from the administration of the prescribed medication as administered or any injury or damages that may result from my/our child's failure to take the prescribed medications as administered by an employee of the St. Thomas More Parish School.
8. I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the above section. I also authorize the exchange of information between the health provider and the school regarding this medication order when deemed necessary by school personnel.

**Parent/Guardian Signature** _____ **Date** _____ **Phone** _____

**Received by** _____ **Date** _____