ASHLAND CITY SCHOOLS

Administrative Offices 1407 Claremont Ave PO Box 160 Ashland Ohio 44805 419-289-1117 Fax 419-289-2303

Administration of Prescription Medication

School policy requires consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can allow a student to possess and use an epinephrine Auto-injector to treat anaphylaxis in school. Please complete this form and return to the school office.

To be completed by LICENSED PRESCRIBER

Student's Name_____ DOB _____

Condition for which medication is administered:_____

Name of Medication, Dose and route:_____

Time or indication for administration:_____

Specific instructions for administration:_____

Possible side effects to be noted/reported: _____

Effective Date_____ Expiration date of this request_____

Instructions to follow in the event medication does not produce expected relief:_____

_____

For ASTHMA INHALERS and INSULIN PUMPS only: In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering an inhaler and/or insulin pump. Yes_____ No_____

_____ _____

Print Licensed Prescriber Name Signature of Licensed Prescriber

_____ _____

Phone Number Date

To be completed by Parent/Guardian

I give permission for designee to administer the medication as prescribed above to my child, and further agree with the following:

- Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.
- Submit to the school personnel a written statement when medication has been discontinued.
- Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
- Cooperate with school personnel in assisting my child to comply with medication administration instructions.
- All medications must come in the original container from the pharmacist.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly for this authorization.

For ASTHMA INHALERS and INSULIN PUMPS only: It is my opinion that my child understands the use of asthma inhaler and/or insulin and demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. Yes_____ No_____

_____ _____ _____

Signature of Parents/Guardian Date Daytime Phone Number

******** This form expires at the end of the school year ********

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