Harvest Preparatory School

MEDICATION or TREATMENT AUTHORIZATION

School Year _____

Ohio law requires ALL of the following information to enable any student to receive prescription medication or prescribed treatment in school. Preschool students must have this form completed for all prescription AND over-the-counter medication.

TO BE COMPLETED BY LICENSED PRESCRIBER

This student is under my care and should receive the following:

Name of Student:_____ Date of Birth _____

MEDICATION/TREATMENT NAME: _____

DOSAGE:_____ TIME:_____ ROUTE: _____

DATES administration to BEGIN:_____ END: _____

Condition warranting medication/treatment: _____

Instruction or precautions including **storage** or **adverse reactions** that should be reported to the physician:

_____

_____ _____ _____ _____

Signature of Licensed Prescriber Title Telephone Number FAX Number

FOR ASTHMA INHALERS and EPINEPHRINE AUTO-INJECTORS

Procedure to follow in the event that medication does not produce the expected relief:

_____

Adverse reactions for unauthorized user: _____

Student has been instructed on proper use of inhaler/ epinephrine auto-injector and is responsible to carry inhaler/ epinephrine auto-injector and self-administer (inhaler). EMS will be notified if epinephrine is used.

_____YES_____NO *A duplicate inhaler/ epinephrine auto-injector must be provided for the clinic.*

PARENT SIGNATURE:_____

Licensed Prescriber Signature: _____

TO BE COMPLETED BY PARENT / GUARDIAN

Name of Student_____Age Date of Birth _____

Address_____

Grade_____ Room_____ Teacher _____

- I am requesting my child receive the medication or treatment listed above at school functions.
- I will assume sole responsibility for safe delivery of the medication to school.
- I will supply the school with medication stored in the **original labeled container from the pharmacy** or store.
- I will supply the school with a **new medical order for any changes** for this prescribed medication or treatment.
- I release and agree to hold the Harvest Preparatory School Board of Education, its officials, and its employees harmless from any and all liabilityfor damages or injury resulting directly or indirectly from this authorization.
- I understand that any medication/supplies that are not picked up **will be discarded one week after the last day of school**.
- My signature, in accordance with HIPAA regulations, gives my permission for release of medical information to the school and/or other health care providers.

_____ _____ _____ _____

Signature of Parent / Guardian Date Home Phone # Daytime Phone