MEDICATION FORM

COLUMBIA LOCAL SCHOOL DISTRICT

25796 Royalton Road, Columbia Station, OH 44028
PHONE: (440)236-1212 FAX: (440)236-8817

FAX TO:
- ☐ Copopa Elementary School (440)236-1220
- ☐ Columbia Middle School (440)236-9274
- ☐ Columbia High School (440)236-3081

INSTRUCTIONS: Physician and Parent must complete and return this form to school before medication will be administered. Medication must be brought to school by parent in its original container.

STUDENT NAME	DATE OF BIRTH	AGE

ADDRESS (STREET, CITY, ZIP)

SCHOOL: ☐ Copopa Elementary ☐ Columbia Middle ☐ Columbia High	GRADE	TEACHER	SCHOOL YEAR

PRESCRIBER AUTHORIZATION

NAME OF MEDICATION	REASON MEDICATION IS TO BE GIVEN AT SCHOOL
DOSAGE	ROUTE/TIMES TO BE GIVEN

BEGINNING DATE	ENDING DATE	REFRIGERATION NEEDED? ☐ Yes ☐ No

SPECIAL INSTRUCTIONS

ADVERSE REACTIONS/TREATMENT	NEXT STEPS IF DESIRED EFFECT NOT MET (EMERGENCY MEDICALTIONS ONLY)

EPINEPHRINE AUTOINJECTOR

☐ 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 its proper use. ***REMINDER - ORC 3313.718 requires a backup epinephrine autoinjector be provided at school*** ☐ Not Applicable _____ (*Prescriber's initials)*

ASTHMA INHALER

☐ Yes, as the prescriber I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in its proper use. ☐ Not Applicable _____ (*Prescriber's initials)*

PRESCRIBER SIGNATURE	DATE	PHONE	FAX

PRESCRIBER NAME, ADDRESS (stamp)

PARENT AUTHORIZATION

☐ I authorize an employee of the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if any medication changes occur. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify any discrepancies. I also understand that all medications must be transported to school by parent/guardian, it must be in the original container, properly labeled by dispenser with student's name, prescriber's name, name of medication, dosage, strength, time interval, route and expiration date. I understand that this is in compliance with ORC 3313.713.

SELF CARRY ☐ I authorize my child to possess and use the above prescribed medication:

- ☐ **EPINEPHRINE AUTOINJECTOR**. I also understand that a school employee will request assistance from an emergency service provider in the event that the medication is administered
- ☐ **ASTHMA INHALER**. The student has been instructed in its proper use

PARENT NAME (PRINT)	#1 CONTACT PHONE

PARENT SIGNATURE	DATE	#2 CONTACT PHONE