



Most Blessed Sacrament Parish School  
4255 Bellevue Road  
Toledo, Ohio 43613  
(419)472-1121

**AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL**

**A NEW FORM MUST BE COMPLETED WHENEVER THE PRESCRIPTION CHANGES AND AT THE BEGINNING OF EACH SCHOOL YEAR.**

Student's name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

This form must be completed with health care provider and parent/guardian signatures AND, if the student is carrying an inhaler, epinephrine auto-injector (EpiPen), or seizure medication the required written information must be received, before any medication can be administered at school. Generally, we discourage the taking of any medication during the school day. There are however, some unique circumstances which require administration of prescribed medication for students. School Personnel will be permitted to administer medications only when no alternative is available.

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**TO BE COMPLETED BY HEALTH CARE PROVIDER**

It is necessary for the following medication to be taken during the school day at the time (s) indicated below:

Date Student examined: \_\_\_\_\_ Diagnosis (optional): \_\_\_\_\_

Medication Prescribed: \_\_\_\_\_ Dosage \_\_\_\_\_

Time: \_\_\_\_\_ Route: \_\_\_\_\_ Side effects: \_\_\_\_\_

Administration to begin: \_\_/\_\_/\_\_ end: \_\_/\_\_/\_\_ Indications for medication: \_\_\_\_\_

Special instructions: \_\_\_\_\_

The named student knows and understands the proper use of his/her inhaler, epinephrine auto-injector (EpiPen), or seizure medication and should be allowed to carry it on his/her person:

**Inhaler:** Yes \_\_\_\_\_ No \_\_\_\_\_ **EpiPen:** Yes \_\_\_\_\_ No \_\_\_\_\_ **Seizure medication:** Yes \_\_\_\_\_ No \_\_\_\_\_

*If YES is marked, the health care provider must have completed all additional information on the second page of this form.*

Health Care Provider's Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_



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**TO BE READ AND COMPLETED BY PARENT/GUARDIAN (or Student if age 18 or older)**

I authorize school personnel to administer the above medication to this student as ordered by the health care provider. I also authorize the school nurse to consult with the Health Care Provider named above about the student's medication needs. I understand that I am responsible for delivering prescribed medication to the student's school in its original container (as labeled by the pharmacy), and for assuring that an adequate supply of the medication has been provided to the school. If the Health Care Provider has indicated that the student should be permitted to carry an inhaler/EpiPen/seizure medication at school, I understand the student is responsible for the proper maintenance and use. I understand that if the student is found to have shared his/her medication with other students. Or otherwise abused the medication or device, the student will not be permitted to carry his/her inhaler/EpiPen/seizure medication at school and disciplinary action may also occur. I understand, and have informed the student that (s)he must notify the school bus driver, principal, nurse or teacher if his/her inhaler/EpiPen/seizure medication is lost or is taken from him/her by another person. In consideration of the administration of medical services as requested and authorized above, I/We, for myself/ourselves, and my/our heirs, executors, administrators and assigns, do hereby waive, release and forever discharge and agree to indemnify and defend the Board of Education of the Diocese of Toledo Schools, its members, officers, administrators, employees, servants, and agents from and against all claims, demands or causes of action by any person or entities for loss, cost, injury or damage whatsoever arising from or claimed to arise from or in any way connected with the administration of medical services to the student named above.

**As Parent(s)/Guardian(s) of the child named above, I/we acknowledge that I/we have read and understand these statements.**

Parent/Guardian name (print): \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse's signature: \_\_\_\_\_ and/or

Principal's signature: \_\_\_\_\_



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**COMPLETE THIS FORM**

Information to be provided by the Health Care Provider when a student is authorized to carry an inhaler, epinephrine auto-injector, or seizure medication.

Name of medication:

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Circumstances in which the medication should be used:

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Procedure's school employees should follow in the event the student is unable to administer the medication or the medication does not produce the expected relief:

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Any severe adverse reactions that may occur to the child using the medication that should be reported to the prescriber:

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Any severe adverse reactions that may occur to another child, for whom the medication is not prescribed, should such a child receive a dose of the medication:

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Per ORC 3313.718, the school principal or school nurse must receive a backup dose of the epinephrine auto-injector for the student to possess and use the auto-injector at school.

It is highly recommended the principal or school nurse receive a backup dose of the inhaler or seizure medication.