PRESCRIPTION MEDICATION FORM

AVON LAKE CITY SCHOOLS

Physician and parent must complete and return form to school before medication will be administered. Medication must be brought to school by parent/guardian in the original container.

Student Information

Student Name			Date of Birth
Student Address			
School	Grade/Class	Teacher	School Year
List any known drug allergies/ reactions			Height/ Weight

Prescriber Authorization

Name of medication		Reason for medication to be given at school	
Dosage	Route	Interval/ Time to be given	
Date to begin medication		Date to end medication	
Special Instructions		Refrigeration needed Yes No	
Treatment in the event of adverse reaction		Next steps if desired effect not met (emergency medications only)	

Epinephrine Rescue Medication: ___Not applicable
___Yes, as the prescriber I have determined that this student is capable of possessing and using this rescue medication appropriately and have provided the student with training in the proper use.
*** Reminder, The parent/guardian or the student shall provide a backup dose of the medication to the principal or school nurse.

Asthma Inhaler: ____ Not applicable
____ 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.

Seizure Rescue Medication: _____Not applicable
_____Yes, as the prescriber I have determined that this student is capable of possessing this rescue medication.

Prescriber Signature	Date	Phone	Fax
Prescriber Name / Address (print/ stamp)			

Parent/Guardian 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 the dosage of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. Further, I release from liability, and indemnify all school employees and the Board of Education, for all damages or injury resulting from the use, misuse, nonuse of such medication except if such Board or its employees are grossly negligent or engaged in wanton or reckless misconduct.
- ✓ Medication and forms must be received by the school nurse and/ or school office. The medication must be in the **original** container and be properly labeled with 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.

Parent/Guardian Signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

- ✓ I authorize my child to possess and use the above prescribed medication and absolve the school of any responsibility in safeguarding this child's medication. The school will not be responsible for ensuring that the child has the medication with him/her and will not be responsible for accidental use of the medication by another child or loss of medication by the student. I authorize my child to possess and use at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

( ) **Epinephrine Rescue Medication:** I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I understand it is my responsibility to provide a backup dose of medication to the school as required by board policy.
( ) **Asthma Inhaler:** The student has been instructed on its proper use.
( ) **Seizure Rescue medication:** I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered.

By Signing below you consent to the above statements.

Parent/Guardian Signature	**Date**	**#1 contact phone**	**#2 contact phone**

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Medication Drop-Off and Pick-Up Instructions

School Year	Date

If your child must take medication during the school year, he/she must have the following:

Part 1: Drop-off and Pick-up Instructions for Parents

Medication drop-off instructions

Parent/Guardian must drop off medication (or designate a responsible adult) to school. **Students may not transport medications or refills.**

The district policy states that you must have:

- Written medication authorization record from your child's licensed health care prescriber and signed permission from the parent/guardian. This form can be obtained from school and from the Avon Lake City School website
- Pharmacy-labeled original bottle or container with student name and prescription details/ number.

Medication pick-up instructions

If your child's medication is discontinued during or after the end of the school year, safe arrangements must be made for the medication to be returned home. Please indicate your choice of how you prefer us to handle the return of your child's medication once discontinued by the health care prescriber or at the end of the school year.

1. _____ I will come to the school office/clinic when my child's medication is discontinued by the health care prescriber or it is the end of the school year.
2. _____ I request that the school dispose of any medication remaining after the last day of school.

If medication is not picked up at the end of the school year all medication will be discarded and will not be stored over summer.

Parent/Guardian Signature	Date

Please contact the school for any questions or concerns.