Medication Authorization at School

NAME OF STUDENT_____

Parent to Complete

Purpose: To permit students to possess and use prescribed medications during school hours when regular attendance at school would be impossible without the medication.

Address **Telephone**

Date of Birth **School** **Room**

To the Parent or Guardian:
THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES OR USES PRESCRIBED MEDICATION IN SCHOOL; BOTH THE PARENT AND HEALTHCARE PROVIDER PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to possess and use medication according to the healthcare provider's verification on this card.
2. I will assume responsibility for the safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I authorize Bishop Hartley Health Services personnel to communicate with my child's healthcare provider as necessary concerning the use of this medication.
5. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent or Guardian **Date**

Home Telephone **Work Telephone**

Healthcare Provider to Complete

To the Healthcare Provider:

The school urges you to schedule the taking of medication by students at times outside of school hours. When that is not possible, the possession and use of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by _____
during school hours: (Student's Name)

(Medication) (Dosage) (Route)

Medication is to be taken at the following times_____
Instructions of precautions (including possible side effects):

Beginning date _____ Expiration Date_____

Healthcare Provider

_____
Signature Date

Printed Name Telephone Number

Address

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Columbus City Schools
Health, Family and Community Services
61 South 6th Street
Columbus Ohio 43215

Guidelines for Medications at School

If medication needs be taken during the school day please follow these guidelines:

- **A new Medication Authorization Form must be completed each school year or when there is a change in the medication or dose.**

- **Have a completed, signed Medication Authorization Form.**
  The parent/guardian must complete the top section and a healthcare provider must complete the medication order section.

  - **All medication must be in the original container in which it was dispensed by the prescribing physician, healthcare provider or licensed pharmacist**.
    - The container must be labeled with the correct dose and instructions.
    - The label should match what is on the Medication Authorization Form.
    - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.

- **School personnel cannot give students over-the-counter medications unless prescribed by a healthcare provider and a Medication Authorization Form is completed.**
  Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, ointments.)

- **Medications ordered three times a day or less, unless there is a time specified, may not need to be given at school.**
  The medication should be given before school, after school and at bedtime.

- **All left over medication must be picked up by the parent/guardian on the last day of school or it will be properly disposed.**

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