



Asthma Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Health, Family and Community Services
Columbus Ohio 43215

Student Name _____ Date of Birth _____ School Year _____

Home Address _____ School _____ HR/Grade _____

Healthcare Provider to Complete:

Columbus City Schools urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of _____

Medication _____ Dosage _____ Route _____

Frequency: Every _____ hours PRN - OR - Give at: _____ (time/s) Begin Date _____ End Date _____ or End of school year

Instructions and precautions _____

Possible side effects to report to the healthcare provider _____

If the medication does not provide relief _____

Other medications prescribed to this student (home & school) _____

For asthma inhaler: The student has demonstrated the proper use of the medication? yes no
The student is capable and may carry and self-administer medication per ORC 3317.716 and 3313.718. yes no

Healthcare Provider Signature _____ Date _____

Provider Name _____

Practice Address _____

Phone _____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name _____ Phone Numbers _____ or _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- Both the parent and healthcare provider portions of this form must be completed.
- A new Medication Authorization form is required each school year and when there is a change in the medication.
- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's inhaler will be stored in the school medication cabinet to ensure its availability for their use and will have the assistance of trained staff as needed unless he/she is authorized to self-carry and administer.
- I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Columbus City School Health Services staff to communicate with the student's healthcare provider as needed.
- 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.
- My student may self-carry and self-administer his/her inhaler as prescribed above, at school/school events if determined capable by myself, healthcare provider and school nurse and understand my student is to report to school clinic/office after using medication. yes no

Parent/Guardian Signature _____ Date _____