Asthma Medication Authorization

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

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ School Immaculate Conception HR/Grade _____

Healthcare Provider to Complete:

Immaculate Conception School 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_____

Administration Time(s)_____ Beginning Date _____ Expiration 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.
- If my student is determined capable to self-carry and self-administer by parent, healthcare provider and school nurse, then I authorize my student to carry and use his/her inhaler as prescribed above, at school/school events: ☐yes ☐no. My student is to report to school clinic/office after using medication.
- 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 the School Nurse to communicate with the student's healthcare provider about the medication as needed.
- I release and agree to hold the Diocese, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____