

**CLYDE-GREEN SPRINGS EXEMPTED VILLAGE SCHOOLS**  
**Authorization for the Administration of Medication by School Personnel**  
As Required by Section 3313.713 Ohio Revised Code

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Teacher

**PARENT/GUARDIAN SECTION**

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. Both the parent (top section) and the licensed prescriber (bottom section) must complete this form
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication). The prescription label must match the instructions from the prescriber. If it is a non-prescription medication, it must be in the original container
3. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.)

**I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.**

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

**LICENSED PRESCRIBER SECTION**

I verify that this medication must be taken by: \_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Diagnosis for which medication is prescribed

\_\_\_\_\_  
Medication

\_\_\_\_\_  
Strength

\_\_\_\_\_  
Dose

\_\_\_\_\_  
Time Medication is to be taken

\_\_\_\_\_  
Administration start date

\_\_\_\_\_  
Expiration date

\_\_\_\_\_  
Instructions or precautions, including possible side effects:

\_\_\_\_\_  
Licensed Prescriber Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Prescriber Printed Name

\_\_\_\_\_  
Phone

CLYDE-GREEN SPRINGS EXEMPTED VILLAGE SCHOOLS  
Self-Medication for Asthma Inhalers  
As Required by Section 3313.716 Ohio Revised Code

Student Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Date the Medication is: to begin \_\_\_\_\_ to end: \_\_\_\_\_

Adverse reactions that should be reported to physician: \_\_\_\_\_

\_\_\_\_\_

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other special instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student has been instructed and has demonstrated proper administration of inhaler:    yes    no

Student is to use inhaler: a. With mouth open and inhaler 1-2 inches away  
b. With spacer  
c. Directly in the mouth

**Physician and parent/guardian names, signatures and emergency phone numbers:**

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Parent/Guardian name: \_\_\_\_\_

Phone: work \_\_\_\_\_ home \_\_\_\_\_ other \_\_\_\_\_

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

1. Both the parent and the licensed prescriber must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. The prescription label must match the instructions from the prescriber.
3. New forms must be submitted each school year and for each medication. New forms must be submitted when any changes in the prescription occur.