Toledo School for the Arts

Physicians Request for Medications Form

Student Info

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

Prescriber Authorization

Name of Medication	Circumstance for use	
Dosage	Route	Time/ Interval
Date to begin medication	Date to end medication	

Circumstance for use

Special Instructions

Treatment in the event of an adverse reaction

Epinephrine Auto Injector (Please check)		Not applicable
		Yes, as the prescriber I have determined that this student is capable of possessing and using this auto injector appropriately and have provided the student with training in the proper use of the auto injector
Asthma Inhaler *(Please check)*		Not applicable
		Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant

Procedures for school employees if the student is unable to administer the medication or if it does not produce expected relief

Possible Severe Adverse Reaction (s) per ORC 3317.716 and 3313.718

a) To the student for whom it is prescribed (that should be reported to the prescriber)

b) To a student for whom it is not prescribed who receives a dose

Other medication instructions:

Does medication require refrigeration Yes No Is the medication a controlled substance? Yes No

Prescriber signature	Date	Phone	Fax

Prescriber Name (Please Print)

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine auto injector and best practice recommends backup asthma inhaler

Parent Authorization

☐ By checking here, I authorize an employee of the school 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

☐ By checking here, I understand that this form must be received by the principal, his/her designee, and/or the school nurse. I understand that 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

Self-Carry Authorization

☐ For Epinephrine Auto injector: As the parent/ guardian of this student, I authorize my child to possess and use an epinephrine auto injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of this medication to the school principal or nurse as required by law

☐ For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the school is a participant.

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