EMMANUEL
CHRISTIAN ACADEMY

2023/2024 Medication Authorization Form for Prescribed Medications

Student Information:

Name:_____ Date of Birth:_____

Address:_____

Grade: _____ Homeroom Teacher:_____ Height:_____ Weight:_____

List any known allergies & reactions:_____

Prescriber Authorization:

Name of Medication: _____ Circumstance for Use: _____

Dosage: _____ Route:_____ Time Interval:_____

Date to begin medications: _____ Date to end medication: _____

Special Instructions: _____

Treatment in the event of an adverse reaction: _____

Epinephrine AutoInjector: ☐ Not Applicable ☐ Trained School Personnel to inject
☐ Yes, as the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector in accordance with ORC 3313.718

Asthma Inhaler: ☐ Not Applicable ☐ Trained School Personnel to administer inhaler
☐ Yes, if conditions are satisfied per ORC 3313.716, the student may possess and use the inhaler at school or at any activity or program sponsored by or in which the student's school is a participant.

Procedures for school employees if the medication does not produce the expected relief:

_____

Possible Severe Adverse Reaction(s) per ORC 3313.718 and 3313.716:

a) To the student for whom the medication is prescribed: _____

b) To a student for whom the medication is not prescribed and receives a dose: _____

Other instructions: Is refrigeration required? ☐ Yes ☐ No Is the medication a controlled substance? ☐ Yes ☐ No

→ Prescriber Signature: _____Prescriber Name (print): _____

Phone: _____ Fax: _____ Date: _____

Parent/Guardian Authorization:

☐ I authorize trained school personnel to administer the above medication.
☐ I understand that additional parent/prescriber signed statements will be necessary if the dosage of the medication is changed.
☐ I authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.
☐ Medication forms must be received by the clinic nurse and/or trained school personnel.
☐ 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.
☐ When delivering the medication to the school, I must fill out a Medication Inventory Record with the clinic nurse or trained school personnel.

→ Parent/Guardian Signature: _____ Parent/Guardian Name (print): _____

#1 Contact Phone: _____ #2 Contact Phone: _____ Date: _____

☐ For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately call 911 if this medication is administered. I will provide a backup dose of the medication to the clinic nurse as required by law per ORC 3313.718.

☐ 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 student's school is a participant.

→ Parent/Guardian Signature: _____ Parent/Guardian Name (print): _____

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Form created & approved by ECA administation 11/2016