THE AMHERST EXEMPTED VILLAGE SCHOOL DISTRICT
185 FOREST STREET, AMHERST, OH 44001
440-988-4406 FAX 440-988-4413
FAX - POWERS 440-988-8674; HARRIS 440-985-1278; NORD 440-988-2371; JR. HI 440-988-0328; HS 440-988-5087

INSTRUCTIONS: PHYSICIAN AND PARENT MUST COMPLETE AND RETURN FORM TO SCHOOL BEFORE MEDICATION WILL BE ADMINISTERED; MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE ORIGINAL CONTAINER.

Student Name	Date of Birth	Age
Address		
School (circle one) Powers Harris Nord AJH Steele	Grade / Teacher	School year

PRESCRIBER AUTHORIZATION

Name of medication	Reason for medication to be given at school
Dosage	Route/Times to be given
Beginning Date	Ending Date
Special instructions	Refrigeration needed Yes No
Adverse reactions/treatment	Next steps if desired effect not met (emergency medications only)

EPINEPHRINE AUTOINJECTOR _____NOT APPLICABLE _____ 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 its proper use

Reminder ORC 3313.718 requires backup epinephrine autoinjector be provided at school

ASTHMA INHALER _____NOT APPLICABLE _____ Yes, as the prescriber I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in its proper use

PRESCRIBER SIGNATURE	Date	Phone	Fax
Prescriber Name, Address (stamp)			

PARENT AUTHORIZATION

I authorize an employee of the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if any medication changes occur. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify any discrepancies. I also understand that all medications must be transported to school by parent/guardian, it must be in the original container, properly labeled by dispenser with student's name, prescriber's name, name of medication, dosage, strength, time interval, route and expiration date. I understand that this is in compliance with ORC 3313.713.

SELF CARRY AUTHORIZATION

I authorize child to possess and use above prescribed medication:

[ ] epinephrine autoinjector. I also understand that a school employee will request assistance from an emergency service provider in the event that the medication is administered

[ ] asthma inhaler – the student has been instructed in its proper use

PARENT NAME (PRINT)

PARENT SIGNATURE	Date	#1 Contact Phone	#2 Contact Phone