MEDICATION AUTHORIZATION
St. Martin School

Ohio State Law requires consent of parent/guardian and doctor before school personnel can give medication to a child.

Name of student _____ Date of Birth _____ Grade _____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN

_____ _____ _____
Name of Drug Dosage & Route Times per day

Side Effects _____

Effective Date _____ Expiration Date _____

FOR INHALERS/ EPIPEN: for students Gr. 5-8, student may carry Yes_____ No _____.

Adverse reactions for unauthorized user: _____

Procedure if inhaler does not produce desired relief _____

Physician's name _____Phone # _____ Fax# _____

Physician's Signature _____ Date _____

THE MEDICINE MUST BE IN A CLEARLY MARKED CONTAINER FROM THE PHARMACIST
The pharmacy label must show the students name, dosage directions, and doctor's name.

TO BE COMPLETED BY THE PARENT

I give my permission for the principal or his/her designee to administer the medication as prescribed above and further agree to the following:

1. Submit to school personnel a revised statement signed by the physician who prescribed above medication when any change in the original physician's statement occurs.
2. Submit to school personnel a written statement when medication given on a daily basis has been discontinued.
3. Understand that it is the student's responsibility to remember to take the medication.
4. Release St. Martin School and their designated personnel from any liability concerning the administration or non-administration of the prescribed medication to the student.

_____ _____
Parent/Guardian Signature Date

I give my permission for my child to carry and self-administer "asthma inhaler/Epipen".

_____ _____
Parent/Guardian Signature Date

THIS PERMISSION IS NO LONGER VALID AT THE END OF THE CURRENT SCHOOL YEAR
Aug/medform