6451 Center Street
Mentor, Ohio 44060

Medication Administration Record

(For administration of <u>All Medication</u> including Epinephrine Autoinjectors and Inhalers)

Student Information

Student Name			Date of birth
Student address			
School	Grade/Class	Teacher	School year
List any known drug allergies/reactions		Height	Weight

Prescriber Authorization

Name of medication	Circumstances for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine autoinjector: (must initial) _____ Student may not carry/possess epinephrine autoinjector. Medication will be stored in school clinic. _____ 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.		
Asthma inhaler: (must initial) _____ Student may not carry/possess inhaler. Medication will be stored in school clinic. _____ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or activity, event, or program sponsored by or in which the student's school is a participant.		
Procedure for school employees if the student is unable to administer the medication or if it does not produce the expected relief.		
Possible severe adverse reaction(s) per ORC 3317.716 and ORC 3313.718 a.) To the student 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 and address (print)			
Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler in clinic			

Parent/Guardian Self-Carry Authorization

_____ For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, 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 request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the 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 student's school is a participant.

Parent/ Guardian Signature	Date	#1 Contact phone	#2 Contact phone

Parent/Guardian must also complete Mentor Public School Parental Permission for Administration of Medication (See reverse side).

Mentor Public Schools

6451 Center Street
Mentor, Ohio 44060

PARENTAL PERMISSION FOR ADMINISTRATION OF MEDICATION

TO: _____ _____
Principal School

FOR: _____ _____
Student Grade

We (I), the undersigned, who are the parent(s)/guardian(s) of _____, request that the administration of a drug be supervised in accordance with the instruction of our physician, _____. We (I) understand that said medication is to be administered under the supervision of a member of the trained school staff, unless otherwise directed by our physician.

Further, we (I) the undersigned, agree to bring the above described medication to school in a container from the pharmacist properly labeled by same, this label to include name of the medication, student's name, physician's name, date, pharmacy name and telephone number, prescribed dosage and frequency and special handling and storage directions. A label is not required for over the counter medication not dispensed by a pharmacist which are drugs prescribed by a physician and which are in their original container.

Administration of the prescribed medication will not be discontinued until the date set forth in the original or revised medication administration record, or until the parent of the child withdraws permission of the Board to administer the medication.

The parent(s)/guardian(s) shall have sole responsibility to instruct their child to take the medication at the scheduled time, and the child has the responsibility for both presenting himself/herself on time and for taking the prescribed medication.

The parent(s)/guardian(s), or other person having care or charge of the student shall immediately submit a revised statement to the building principal signed by the physician who prescribed the medication if changes are made to the medication treatment plan.

**Signature of Parent/Guardian: _____ Date: _____

Address of Parent/Guardian: _____

Telephone Number: Home: _____ Business: _____ Cell: _____

**If children are in a foster home and placement is by an agency that holds custody, agency personnel must sign. If the child is a ward, a court- appointed guardian must sign.

This section to be completed by school personnel:

Person(s) authorized to supervise consumption of medication for this student: (the building administrator may, as set forth in board policy, designate a staff member to supervise the storage and dispensation of medication.)

_____

_____

Signature of Principal **Date**