Constellation Schools

Lorain Community Elementary and Middle

"The Right Choice for Parents and a Real Chance for Children"

Please use (1) Medication Request Form per (1) medication

Student Name: _____ Grade: _____ Date of Birth: _____

Address: _____ Phone: _____

Prescriber Authorization

Name of Medication: _____ **Reason for use** _____

Dose: _____ Route _____ Time/Frequency: _____

Start Date: _____ Stop Date: end of current school year Other Stop Date: _____

Special instructions/restrictions: _____

Epinephrine Autoinjector ❑ Not applicable ❑ No, student may NOT self-carry
❑ Yes, this student may self-carry Epinephrine. 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.(ORC 3313.718)

Asthma Inhaler ❑ Not applicable ❑ No, student may NOT self-carry
❑ Yes, if conditions are satisfied per ORC 3313.716, the student may self-carry (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 the expected relief:

_____

Possible Severe Adverse Reaction(s) per ORC 3313.716 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 _____

Treatment in the event of an adverse reaction _____

Prescriber Signature: _____ Date: _____

Prescriber Name (print): _____ Phone: _____

Address: _____ Fax: _____

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Parent/Guardian Authorization

I give permission for authorized school personnel to follow the medical instructions above for my child in accordance with school policy.

I agree to:

- Deliver medication to the school in its original container, properly labeled per school policy, or have it delivered by a responsible adult.
- Have a new form completed by the Prescriber if medication or dosage is changed.

I give my consent to the Prescriber, school nurse or their designees to send and/or receive information related to my child's medication for the duration of this order as noted above.

For self-carry Epinephrine I authorize my child to possess and use the Epinephrine as prescribed at the school or any school sponsored event. I Understand that a school employee will immediately call 911 if this medication is administered, I agree to provide a back-up dose of this medication to be kept locked in the school office/clinic as required by law.

For self-carry Asthma Inhaler I authorize my child to possess and use an asthma inhaler as prescribed, at school or any school sponsored event. I agree to provide a back-up inhaler to be kept locked in the school office/clinic as required per school policy.

Parent/Guardian Signature: _____ Date: _____

Ohio Revised Code 3313.203, 3313.56, 3313.671, 3313.712, 3313.713, 3313.718 Pursuant to Ohio Administrative Code 4723-13-03, 4723-13-05, 4723-13-07