HILLIARD CITY SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM - C
PRESCRIBER AUTHORIZATION

PURPOSE: Completion of this form is necessary to comply with the Ohio Revised Code 3313.713 & 3313.718 and Hilliard Board of Education policy.

INJECTABLE MEDICATION

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Route: _____ Time: _____

FOR TREATMENT OF:

__ Medical diagnosis of: _____

__ STING ALLERGY - Specify insect if known: _____

__ FOOD/SUBSTANCE ALLERGY - Child may have an anaphylactic reaction to: _____

_____

Circumstances under which this medication should be administered: _____

_____

NOTE: SCHOOL PERSONNEL WILL CALL 911 WHEN AN EPIPEN IS ADMINISTERED.

Any additional emergency follow up: _____

Is student able to self-carry and self-administer auto-injector? ____ YES* ___NO**

* By checking "yes" above, I acknowledge that I have deemed the student capable of possession and self-administration of the auto-injector and have provided them with appropriate training. I also understand that I must prescribe at least two injectors for use at school, as required by ORC 3313.718.

** If the prescriber or school nurse determines the student to be incapable of possession or self-administration, the auto-injector will be stored and administered as deemed appropriate by school officials and outlined as such in the student's Emergency Care Plan.

Instructions to be followed in the event the student is unable to self-administer and/or the medication does not produce the desired result: _____

_____

Possible side effects of medication: _____

Beginning date: _____ Expiration date: _____ Today's date: _____

PRESCRIBER'S SIGNATURE: _____ Phone Number: _____

PRESCRIBER'S address/office stamp: _____