HILLIARD CITY SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM - D
PRESCRIBER AUTHORIZATION

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

TO THE PRESCRIBER: The Hilliard Board of Education urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the receiving and consumption of medications will be permitted, insofar as feasible, during school hours.

NEBULIZED MEDICATION

Name of student: _____ DOB: _____

Medication: _____ Dosage: _____ Time: _____

Possible side effects to be reported to physician: _____

Special instructions: _____

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

PRESCRIBER'S SIGNATURE: _____ Phone Number: _____

Prescriber's address/office stamp: _____

Revised 11/05