HILLIARD CITY SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM - B
LICENSED 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.

ORAL/MISCELLANEOUS MEDICATION

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Route: _____ 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: _____

INHALED MEDICATION

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Route: _____ Time: _____

CHILD HAS PERMISSION TO CARRY AND SELF ADMINISTER: _____ YES _____ NO
(If NO, inhaler will be kept in school clinic/nurse's office.)

Possible side effects to be reported to physician: _____

Special instructions in the event that medication does not provide relief from asthma attack:
_____

Possible adverse reactions for unauthorized user: _____

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

PRESCRIBER'S SIGNATURE: _____ Phone Number: _____

Prescriber's address/office stamp: _____