The Stark County Public Schools

Licensed Prescriber's Order for Asthma Inhalers on Reverse Side

Licensed Prescriber's Order for Prescribed Oral Medication

Both State Law ORC and all public schools within Stark County require the following information when children need administration of prescription drugs. Please complete the following information and forward to the school.

1. Name of Student _____ Age _____
   Last First Middle
2. Address _____
3. School District _____ Bldg. _____ Class/Grade _____
4. Name of Medication _____ Oral Dosage _____
5. Times at which the medication is to be administered _____
   _____
6. Administration of Medication to begin _____
7. Administration of Medication to end _____
8. Significant Side Effects (Adverse reactions) which should be reported to the licensed prescriber. _____
   _____
9. Special instructions for administration of the drug, including sterile conditions and storage. _____
   _____

_____ _____
Licensed Prescriber Signature Licensed Prescriber Emergency Phone #

_____ _____
Parent/Guardian Signature Parent/Guardian Phone Number

NOTE: There must be notification to school employees if any information provided by the licensed prescriber changes.

The medication must be delivered to the school by the parent/guardian in the container in which it was dispensed by the licensed prescriber or licensed pharmacist.

Date _____

This form has been approved by the Stark County Medical Society.

NOTE: Licensed Prescriber in Stark County have this form in their offices.

1998/2005

Self-Medication for Asthma Inhalers

Authorization Form

As Required by Ohio Revised Code 3313.716

Student Name:_____ Date_____

Address_____ City_____ Zip_____

Medication Name:_____

Dosage_____

Date the administration is to begin_____

Date the administration is to cease:_____

Adverse reactions that should be reported to the licensed prescriber:_____

_____

Adverse reactions for unauthorized users:_____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:_____

_____

_____

Other special instructions:_____

_____

_____

Licensed Prescriber and parent/guardian names, signatures and emergency phone numbers:

Licensed Prescriber Name (print)_____ Phone #_____

Licensed Prescriber Signature_____ Date_____

Parent/Guardian Name (print)_____ Phone #_____

Parent/Guardian Signature_____ Date_____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.

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