Medication Drop-Off and Pick-up Instructions
for Parent/Guardian

School Year	Date

Dear parent of _____,
Student Name

If your child must take medication during the school year, he/she must have the following:

Part 1: Drop-off and Pick-up Instructions for Parents

Medication drop off instructions

Parent/guardian must drop off medication (or designate a responsible adult) to deliver the medication to school designated location.

The Ohio Revised Code and school district policy state you must have:

❑ Written medication authorization record from your child's licensed health care prescriber and signed permission from the parent/guardian (school will provide necessary forms).

❑ Pharmacy-labeled original bottle or original container with student name and grade if non-prescription.

Other Comments

Medication pick up instructions

If your child's medication is discontinued **during** or **after the end of the school year**, safe arrangements must be made for the safe return. Please indicate your choice of how you prefer us to handle the return of your child's medication once discontinued by the health care prescriber or at the end of the school year.

❑ I will come into the school office/clinic when my child's medication is discontinued by the health care prescriber or it is the end of the school year.

❑ I request that the school dispose of any medication remaining after the last day of school. (If this form is not returned, medication will be properly discarded _____ week(s) after school ends.)

I give the school permission to send my child's:

❑ Epinephrine autoinjector or

❑ Asthma inhaler home with my child on this date _____. I assume all responsibility for the medication after it leaves the school.

Parent/Guardian signature	Date	#1 Contact phone	#2 Contact phone

Part 2: For School Nurse/Personnel Only

Your child, _____ has _____ of _____ left in the clinic.
(amount left) (medication name)

Please follow all medication instructions above to ensure safe medication practice.

School nurse/School personnel signature	Title	Phone	Date

Please contact the school for any questions or concerns

❑ File per district policy

Medication Administration Record (MAR)
General Medication Form
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name				Date of birth
Student address				
School	Grade/Class	Teacher		School year
List any known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine Autoinjector ❑ Not applicable ❑ Yes, 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.		
Asthma Inhaler ❑ Not applicable ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may 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 3317.716 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		
Other medication instructions Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No		
Prescriber signature	Date	Phone / Fax
Prescriber name (print)		
Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.		

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

❑ *medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

❑ *For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

❑ File per district policy

Self Carry Asthma Inhaler Agreement

Student Information

Student's name	Grade/Classroom
☐ I plan to keep my asthma inhaler with me at school as my doctor or health provider ordered. Location of my asthma inhaler: _____ ☐ I agree to use my asthma inhaler in a responsible manner as ordered. ☐ I will notify the school health office immediately if my asthma inhaler has been used and if my asthma attack does not get better. ☐ I will never allow any other person to use my asthma inhaler.	
Student signature	Date

Parent/Guardian

This contract is in effect for the current school year unless revoked by the physician or licensed health provider, or if my child fails to meet the above safety contingencies.

- ☐ I agree to see that my child carries their medication as prescribed, that the asthma inhaler always contains medication that has not expired.
- ☐ It has been recommended that it is best practice to have a "back-up" asthma inhaler available at the designated school health clinic or office for emergencies.
- ☐ I will review the health status with my child's health care provider on a regular basis and notify the school if anything changes, including a parent/guardian emergency numbers.

Parent/Guardian signature	Date
Emergency Contact Number (Available at all times)	

Nurse at School and/or Designated School Personnel

- ☐ The student above has demonstrated correct technique for asthma inhaler use, and understanding of the physician order for emergency use.
- ☐ The physician has completed the appropriate medication authorization record to self carry.
- ☐ School staff that has the need to know about the student's condition and the need to carry an asthma inhaler have been notified and trained according to ORC3313.713.

Nurse signature	Date
School Personnel	Date
School Administrator/Principal signature	Date

☐ File per district policy

Epinephrine Autoinjector (Epi-Pen®) Self Carry Agreement

May Include in Student's Individualized Healthcare Plan (IHP)

Student Information

Student name	Grade/Classroom:

- ☐ I plan to keep my epinephrine autoinjector with me at school as my doctor or health provider ordered.
  Location of my epinephrine autoinjector: _____
- ☐ I agree to use my epinephrine autoinjector inhaler in a responsible manner as ordered.
- ☐ I will notify the school health office immediately if my epinephrine autoinjector has been used.
- ☐ I will never allow any other person to use my epinephrine autoinjector.

Student signature	Date

Parent/Guardian

This contract is in effect for the current school year unless revoked by the physician or licensed health provider, or if my child fails to meet the above safety contingencies.

- ☐ I agree to see that my child carries their medication as prescribed, that the epinephrine autoinjector always contains medication that has not expired.
- ☐ I was notified that Ohio law requires a "back-up" epinephrine autoinjector is available at the designated school health clinic or office for emergencies. {ORC 3313.718 (3)}
- ☐ I will review the health status with my child's health care provider on a regular basis and notify the school if anything changes, including a parent/guardian emergency numbers. {ORC 3313.713 (k)}

Parent/Guardian signature	Date
Emergency contact number (Available at all times)	

Nurse at School and/or Designated School Personnel

- ☐ The student above has demonstrated correct technique for epinephrine autoinjector use and understanding of the physician order for emergency use.
- ☐ 911 will always be called if student uses the epinephrine autoinjector during school hours.
- ☐ School staff that has the need to know about the student's condition and the need to carry an epinephrine autoinjector have been notified and trained according to ORC 3313.713.

Licensed Health Professional signature	Date
Designated School Employee signature	Date
School Administrator/Principal signature	Date

☐ File per district policy