Perkins Local School District

Medication/Drug Therapy at School Consent
In accordance with ORC 3313.716, 3313.718, 3314.141, 3313.713, 4729.01 and HB 264

To Parents or Guardians:
Any medication or drug to be used on school grounds shall only be given if absolutely necessary and with proper and complete documentation in accordance with state law and Board policy. This includes prescription and non-prescription medication/drug therapies. Please complete this form and return it to your school nurse.

STUDENT INFORMATION:

Student Name:	Date of Birth:

Address:

School:	Grade:	Teacher:	School Year:

List any known allergies:

MEDICATION/DRUG THERAPY INFORMATION:

Name:	Reason for use:

Dosage:	Route:	Time/Interval:

Start Date:	End Date:

Special Instructions:

Adverse Reactions to Report and Treatment if it Occurs:

PRESCRIBER AUTHORIZATION:

Printed Name:	Date:
Signature:	
Phone Number:	

Prescriber information and signature MUST be obtained if a nurse or school staff member is to administer the medication/drug therapy – Including any prescription and non-prescription medications or therapy.

PARENT/GUARDIAN AUTHORIZATION:

Check all that apply:

- ❑ I authorize my child to self possess and use an epinephrine autoinjector, asthma inhaler, and/or diabetic care supplies as prescribed. I acknowledge that my child is trained in the medications and supplies use/disposal. Should the autoinjector be used, I understand that 911 will be called to respond.
- ❑ I understand that a backup epinephrine autoinjector is required per ORC 3313.718 and a back up inhaler is strongly recommended to be kept secure in the nursing clinic.
- ❑ I authorize a school nurse or designated employee to administer the medication/drug therapy as documented above and have obtained the necessary prescriber signature.
- ❑ I understand that I will supply all medications in the original container with labels intact as required by state law.
- ❑ I agree to submit new consent forms every school year and with any changes to the medication/therapy.
- ❑ I understand all medication/drug therapy will be kept securely locked in the nursing clinic unless outlined above.
- ❑ I understand that medication/drug therapy is never to be shared between students under any circumstances.
- ❑ I agree that any medication/drug therapy will be transported to the school by an adult, not the child.
- ❑ I understand that any aromatherapy drug (to include essential oils) will not be permitted to be diffused into the air inside of any Perkins building. If it is absolutely necessary for your student to topically use such drug therapy during school hours, the product must be kept in the locked medication cabinet in the nursing clinic and must be self applied by the student. If it requires application by any staff member, a physician's order and signature are required. I further acknowledge to assume all risks and responsibility for side effects associated with these drug therapies. Should others be affected by the aromatherapy in a way that affects their own health, I agree to seek alternatives as to not cause harm to others.

Parent/Guardian Signature: _____Date:_____

Complete if Applicable

Epinephrine Autoinjector, please check if applicable for self carry:

- ❑ Yes, as the prescriber I have determined that the student is capable of possessing and using the autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

NOTE: A backup autoinjector MUST also be kept in the Nurse's Clinic (ORC 3313.718) and 911 emergency responders will be initiated in accordance with Board Policy if the autoinjector is used.

Prescriber's Initials:

Asthma Inhaler, please check if applicable for self carry:

- ❑ Yes, as the prescriber, I have determined that the student is capable of possessing and using the inhaler appropriately and have provided the student with training in the proper use of the inhaler.

NOTE: Best practice recommends a back up inhaler be kept in the Nurse's Clinic.

Prescriber's Initials:

Diabetes, please refer to Diabetes Medical Management Plan (DMMP). Please check if applicable for student to self carry and manage diabetes care independently.

- ❑ Yes, as the prescriber, I have determined that the student is capable of managing their diabetes independently including appropriate use and disposal of supplies.

Prescriber's Initials: