AVON LOCAL SCHOOL DISTRICT
36600 DETROIT RD. AVON, OHIO
440-937-4680 FAX
FAX - ELC 934-2147; EAST 937-5525 ; HERITAGE 937-9620; MIDDLE 934-3803 ; AHS 934-5450

INSTRUCTIONS: PHYSICIAN AND PARENT MUST COMPLETE AND RETURN FORM TO SCHOOL BEFORE MEDICATION WILL BE ADMINISTERED; MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE ORIGINAL CONTAINER. Per ORC 3313.713

Student Name	Date of Birth	Age
Address		

School (circle one) ELC EAST Heritage Middle AHS	Grade	Teacher	School year

PRESCRIBER AUTHORIZATION

Name of medication	Reason for medication to be given at school
Dosage	Route/Times to be given
Beginning Date	Ending Date
Special instructions	Refrigeration needed Yes No
Adverse reactions/treatment	Next steps if desired effect not met (emergency medications only)

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 its proper use

Reminder ORC 3313.718 requires backup epinephrine autoinjector be provided at school

ASTHMA INHALER _____NOT APPLICABLE _____ Yes, as the prescriber I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in its proper use

PRESCRIBER SIGNATURE	Date	Phone	Fax
Prescriber Name, Address (stamp)			

PARENT 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 any medication changes occur. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify any discrepancies. Further, I hereby release from liability, and in addition, agree to indemnify all school employees, the Board of Education, and Lorain County General Health District employees, for all damages or injury resulting from the use, misuse, nonuse of such medication except if such Board of its employees are grossly negligent or engaged in wanton or reckless misconduct.

SELF CARRY AUTHORIZATION

I authorize child to possess and use the above prescribed medication and absolve the school of any responsibility in safeguarding our child's medication(s). The school will not be responsible for ensuring that the child has the medication(s) with him/her and will not be responsible for accidental use of the medication(s) by another child or loss by the student.

[ ] epinephrine autoinjector. I also understand that a school employee will request assistance from an emergency service provider in the event that the medication is administered

[ ] asthma inhaler – the student has been instructed in its proper use

PARENT NAME (PRINT)

PARENT SIGNATURE	Date	#1 Contact Phone	#2 Contact Phone