MONROE LOCAL SCHOOLS MEDICATION PERMIT

In accordance with Ohio Revised Code 3313.713 a new permit is required each school year and with any changes of medication or treatment. Monroe Local Schools requires that the following information be provided before it will administer medication or treatment to the student**.**

Monroe Primary School Clinic Phone: 513-360-0552 Fax: 513-360-0720	Monroe Elementary Clinic Phone: 513-360-0510 Fax: 513-539-8151	Monroe Jr/Sr High School Clinic Phone: 513-360-0526 Fax: 513-539-8474

Dear Parent/Guardian,

This School Medication Permit must be completed if your child will need to take **over-the-counter (OTC) medication** *or* **prescription medication** during school hours. Both you and your child's doctor or licenses prescriber must complete sections of this form. Medication provided to school must be in the **original (OTC) container** *or* the **prescription bottle.** The parent/guardian must bring the medication to the school clinic. The medication will be administered, as ordered, by a staff member trained to administer medications.

Directions to complete the School Medication Permit for medication that will be stored in the school clinic and administered by a trained staff member.

1. The Parent/Guardian must complete the 1st box.
   Leave the 2nd box blank unless you and your child's doctor authorize your child to carry and self-administer either an Asthma Inhaler or an Epinephrine Auto injector.
2. The child's doctor or licensed prescriber must complete the 3rd box.

Directions to complete the School Medication permit if you intend for your child to carry/self administer either an Asthma Inhaler or an Epinephrine Auto injector.

Please Note: ALL of the following conditions **MUST** be met or your child's Asthma Inhaler or Epinephrine Auto injector will be stored in the school clinic and administered by trained staff:

1. The Parent/Guardian must complete the 1st box on the school medication permit.
2. The Parent/Guardian must complete the 2nd box on the school medication permit, giving parental/guardian permission for the child to carry and self-administer the medication.
3. **The child's doctor or licenses prescriber must authorize the child to carry and self-administer an Epinephrine Auto injector by "checking" the statement in the 3rd box that states,**

_____AUTHORIZATION FOR CHILD TO CARRY/SELF ADMINISTER AN ASTHMA INHALER OR EPINEPHRINE AUTO INJECTOR AS PRESCRIBED.

4. A second Epinephrine Auto injector must be provided to school and stored in the school clinic if your child is authorized to carry/self-administer an Epinephrine Auto injector. Please call the clinic if you have any questions regarding your child's health.

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THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student_____ Date of Birth_____

Student's Address_____ School_____ Grade_____ Homeroom_____

A. I am requesting permission for my child named above to: **(Check all that apply)**
___ receive medication from an authorized staff member in accordance with the authorized prescription written below.
____ carry & self-administer an asthma inhaler and/or epinephrine auto injector in accordance with the authorized prescription written below.
____ receive prescribed treatment in accordance with the authorized prescription written below.

B. I will assume responsibility for safe delivery of the medication/drug to school. Medication may not be sent to school in the student's lunch box, pocket, backpack, or any other means on or about his/her person.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. I understand a new School Medication Permit must be completed and submitted to school each time changes are made to the prescription or treatment.

D. I release agree to hold the Monroe Board of Education, it's officials, and its employees harmless from any and all liability foreseeable, unforeseeable, for damages or injury resulting directly or Indirectly from this authorization.

*If the licenses provider authorizes the student to carry and self-administer an asthma inhaler or an epinephrine autoinjector:

- Parent/Guardian will provide a backup dose of the medication (Epinephrine) to the school principal or nurse as required by law.
- It is strongly recommended the parent/guardian provide a second inhaler to be stored in the clinic in the event the student does not have inhaler.
- The student should be responsible to report use of inhaler to the nurse and/ or principal.
- The parent/guardian must sign and date the Carry/Self-Administer box below and the licensed prescriber must check the Carry/Self Administer Authorization.

Parent/Guardian Signature_____Date_____ Daytime Phone_____ Cell Phone_____

Parent/Guardian Authorization for Child to Carry/Self-Administer an Epinephrine Autoinjector or Asthma Inhaler

- For Epinephrine Auto injector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is participant. I understand that a school employee will immediately request assistance for an emergency medical service provider if this medication is administered.
- 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_____

THIS SECTION TO BE COMPLETED BY LICENSED PRESCRIBER

I am a licensed health professional authorized to prescribe drugs, and I have a prescribed the following medication to the above named student.

Medication_____ Date of Authorization_____ Dosage_____

Time(s) to be given_____ Start Date_____ End Date_____

_____ AUTHORIZATION FOR CHILD TO CARRY/SELF ADMINISTER AN ASTHMA INHALER OR EPINEPHRINE AUTOINJECTOR AS PRESCRIBED.

Adverse reactions to be reported_____

Adverse reactions if used by unauthorized person_____

Diagnosis_____

Licensed prescriber emergency phone#_____Alternate phone#_____

Special Instructions_____

Administration_____

–

Storage_____

Prescriber name(print)_____Signature/Date_____

Prescriber Address_____

FOR SCHOOL USE ONLY

The following school personnel have read this form and are authorized to administer medication as outlined:

Nurse's Signature_____ Date _____

Signature _____ Date _____

Signature _____ Date _____