Crestview Schools
1575 State Route 96
Ashland, Ohio 44805
419-895-1700
Fax 419-895-1733

Health forms for students taking

Medications at School

Please complete packet and return to the nurse at your child's school.

What is in this packet?

1) Release of Information allows the doctor to talk to the school nurse if there are any questions

2) Guidelines for Medicines at School – parent reference

3) Medication Authorization - must be signed by parent and doctor and brought to school with the medication in the original bottle/container. One Medication Authorization form per medication. Medicine cannot be at school without signatures of both the doctor and parent.

4) For any Emergency Medications, an Emergency Action Plan (EAP) must be filled out. See specific forms for Food allergies, Allergies, Seizures,or Diabetes for those proper Emergency forms.

Questions - Please call your school nurse.

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AUTHORIZATION FOR RELEASE OF INFORMATION

CHILD'S NAME: _____

DATE OF BIRTH: _____ **STUDENT #:**_____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the party indicated and Crestview Local Schools.

_____ Obtain Information From: _____
_____
_____

_____ Release Information To: _____
_____
_____

_____ Medical Information/Records

_____ TB Test Results/Records

_____ Immunization Records

_____ Achievement and Aptitude Test Scores

_____ Psychological Information/Records

_____ Grades and Attendance

_____ Speech and/or Hearing Evaluation

_____ Individual Education Plan (IEP), if in Special Education

_____ Other Information, as specified: _____
_____
_____

This information to be used for: _____

_____ _____
Parent/Guardian Signature Date

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Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy** and be labeled with the correct dose and instructions.
    - The label must match what is on the Medication Authorization Form.
    - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
    - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **School personnel cannot give over-the-counter medications unless Final Forms have been completed and signed by a parent or guardian.**

- Prescribed medications can not be administered by school personnel unless medication Authorization Forms are completed and submitted to the school.

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

All unused medication must be picked up by the parent/guardian on the last day of school or it will be discarded.

Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

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Student Name_____ Date of Birth_____ School Year_____

Home Address_____ School_____ HR/Grade _____

Healthcare Provider to Complete:

Crestview Local Schools urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of_____

Medication_____ Dosage_____ Route_____

Administration Time(s)_____ OR ⫽ Every _____ hours as needed for_____

Beginning Date _____ Expiration Date_____ /End of school year

Instructions: _____

_____

Precautions and possible side effects_____

Other medications prescribed to this student (home & school) _____

_____

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to receive the medication as ordered above.
- I understand the medication must not be expired, be in the original container and labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Crestview Local School Health Services staff to communicate with the student's healthcare provider as needed.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____