School Year: _____
Campus: _____

Cincinnati Classical Academy

Prescription Medication Authorization Form

Student Information

Student Name & Address	Date of Birth	Grade/ Homeroom	Student Allergies

Medication Information

Medication	Dosage	Time	Duration	Other
			Date beginning: _____ *Date ending:* _____ ☐ *duration of school yr*	☐ *This medication is a controlled substance* ☐ *This medication needs refrigerated*

Possible Severe Adverse Reactions to be Reported to the Physician

Self-Carry Information

☐ *Yes* ☐ *No* Does this student need to carry this medication on him/her at all times?

☐ *Yes* ☐ *No* Has this student been instructed on proper use for this medication?

Procedure for school employees if student does not get expected relief from dose:

Possible reaction to report to physician if student not prescribed this medication receives a dose:

Prescriber Authorization

☐ As the prescriber, I have determined that the student is capable of possessing and using medication appropriately and have trained him/her on proper usage and administration

Physician Signature	***Physician Name (Print)***	***Date***	***Physician ER Phone #:***

Parent Permission

By signing this form, I give permission for the designated employee at Cincinnati Classical Academy to give the above medication to my child while at school, I agree to deliver the medication to the School Nurse in the properly labeled pharmaceutical container. I further release Cincinnati Classical Academy from any liability concerning the administration or non-administration of the medication to my child for the medication as ordered.
(Self Carry) I authorize my child to possess and use this medication (epi, insulin, or inhaler only) as prescribed, at the school and any activity, event, or program sponsored by or in which my child's school is a participant.
(Self Carry) I will provide a backup dose of the medication to the school nurse as ***required by law*** *(ORC 3313. 718).*

Parent Signature: _____ Phone #: _____ Date: _____

NO MEDICATION WILL BE GIVEN WITHOUT THIS SIGNED FORM FROM PARENT & PROVIDER.
ONLY 1 MEDICATION FOR FORM
VALID FOR ONE SCHOOL YEAR