

# Mac-A-Cheek Learning Center

1130 W. Sandusky Ave., Bellefontaine, OH 43311  
Phone - 937-404-1263 Fax - 937-292-7035

## AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS

in accordance with Ohio Revised Code 3313.716/3313.714

A completed form must be provided to the school principal and/or the school nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Part A, Part B, and Part C must be completed.

### PART A - PHYSICIAN (PRESCRIBER) MUST COMPLETE

Student's Name		Date of Birth
Student's Address		City Zip
Medication Name	Dosage	
Authorization is hereby given for the student named above to:		Beginning Date of Medication Administration:
<input type="checkbox"/> receive the prescribed medication from designated school personnel		Ending Date of Medication Administration:
<input type="checkbox"/> carry and self-administer the prescribed medication as permitted by law*		
* If the prescriber or the school nurse determines the student to be incapable of possession or self-administration, the asthma inhaler will be stored and administered as deemed appropriate by the school nurse or school officials and outlined as such in the student's Emergency Care Plan.		
Circumstances for use of Asthma Inhaler:		
Special Instructions:		
Adverse Reactions That Should Be Reported to Physician:		
Procedure to follow in the event that medication does not produce the expected relief from asthma attack:		
Adverse Reactions for Unauthorized User:		
Physician's Name: _____		Phone: _____
Physician's Signature _____		Date: _____

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A completed form must be provided to the school principal and/or the school nurse before the student may receive medications/treatments at school.  
Part A, Part B, and Part C must be completed.

### PART B. - PARENT/GUARDIAN MUST COMPLETE

Student's Name	Date of Birth	
Student's Address	City	Zip
Medication/Treatment		

### PARENTAL AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent: The following information is necessary for any student to use prescribed medications or to receive treatment in school.

- A. I am requesting permission for my child named above to use the prescribed medication/treatment in accordance with the Physician's prescription.
- B. I will assume responsibility for the safe delivery of the medication/supplies to school if medication is given by staff.
- C. I will immediately notify the school in writing if there is any change in the use of the medication or the prescribed treatment.
- D. I understand that if my child abuses their inhaler or gives it to another student to use, He/she will lose the privilege of carrying their inhaler with them and will have to leave their inhaler with designated staff, this will be written in their Emergency Care Plan.
- E. I release and agree to hold the Governing Board, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent(Guardian)'s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent(Guardian)'s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PART C - SCHOOL MUST COMPLETE

#### AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above prescribed medication or treatment.

\_\_\_\_\_  
School Nurse, Teacher, Teaching Assistant, One-to-One Assistant, Head Teacher, Principal, Registered Nurse, Licensed Practical Nurse

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_