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 EPINEPHRINE AUTO INJECTOR

in accordance with Ohio Revised Code 3313.718/3313.714

A completed form must be provided to the school principal and/or the school nurse before the student may possess and use am asthmas 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 and Dosage	**Allergy(ies)**	
Authorization is hereby given for the student named above to: ☐ receive the prescribed medication from designated school personnel ☐ carry and self-administer the prescribed medication as permitted by law*. I have determined that this student is capable of possessing and using this auto injector appropriately and have provided the student with training in the proper use of the auto injector.	**Beginning Date of Medication Administration:** **Ending Date of Medication Administration:**	

*** If the prescriber or the school nurse determines the student to be incapable of possession or self-administration, the Epinephrine Auto injector 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 Epinephrine Auto Injector:

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 allergic reaction:

Adverse Reactions for Unauthorized User:

Physician's Name: _____ **Phone:** _____

Physician's Signature _____ **Date:** _____

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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 Signatu _____ **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:** _____