6905 Given Road, Cincinnati, Ohio 45243
School Nurse Phone: (513)979-0250

Prescription Medication Orders From Physician

Return this form ***ONLY IF*** your child ***might*** need to take medication during school hours, overnight field trips or sports activities. **Medications will not be administered unless there is a medication order on file signed by the physician and parent/guardian.**

Student Name and Address	Grade/Division **2021-2022**	Date of Birth

Medication	Dosage	Time	Duration
			Beginning: _____ Ending: _____

Possible reactions to be reported to the physician.

Epi-Pen, Insulin, or Inhaler Self Carry Section

Does this student need to carry this medication with him at all times? _____ Yes _____ No

Has this student been instructed on proper use of this medication? _____ Yes _____ No

Procedures for school employees if the student is unable to administer the medication or it does not produce the expected relief.
Possible reactions to be reported to physician if a student for which medication is **NOT** prescribed receives a dose.

As the prescriber, I have determined that this student is capable of possessing and using an autoinjector appropriately and have provided the student with training in the proper use of the autoinjector. **Initial** _____

Signature of Physician (*Required*): _____ **Physician ER Phone:** _____

Physician Name *(Print)*: _____ **Date:** _____

Parent Permission

I, _____, the parent or guardian of _____ gives permission for the medication ordered by the above physician to be given at school. I further agree to:

1. Deliver the medication to the School Nurse in the properly labeled pharmaceutical container
2. Release Cincinnati Country Day School from any liability concerning the administration or non-administration of the medication to the student.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. If the medication is not able to be administered, the school will immediately request assistance from an emergency medical service provider. ***I will provide a backup dose of the medication to the school principal or nurse as required by law (ORC 3313.718).*** **Initial** _____

As a 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 students' school is a participant. **Initial** _____

No medication will be given without a doctor's order/One medication per form/applies only to current school year