



Columbus City Schools Health, Family and Community Services

Prescribed Medication Authorization

NAME OF STUDENT _____

Parent to Complete

Purpose: To permit students to possess and use prescribed medications during school hours when regular attendance at school would be impossible without the medication.

Address _____ Telephone _____

Date of Birth _____ School _____ Room _____

To the Parent or Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES OR USES PRESCRIBED MEDICATION IN SCHOOL; BOTH THE PARENT AND PHYSICIAN PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification on this card.
2. I will assume responsibility for the safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I authorize Columbus City School Health Services personnel to communicate with my child's health care provider as necessary concerning the use of this medication.
5. 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.

Signature of Parent or Guardian _____ Date _____

Home Telephone _____ Work Telephone _____

Physician to Complete

To the Physician:

The Columbus Board of Education urges you to schedule the taking of medication by students at times outside of school hours. When that is not possible, the possession and use of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by _____
during school hours: (Student's Name)

(Medication) _____ (Dosage) _____ (Route) _____

Medication is to be taken at the following times _____

Instructions of precautions (including possible side effects): _____

Beginning date _____ Expiration Date _____

Physician _____
Signature _____ Date _____

Printed Name _____ Telephone Number _____

Address _____

Guidelines for Medications at School

- **All medication must be in the container in which it was dispensed** by the prescribing physician or licensed pharmacist.
- Any student needing to take medication during school hours **must have a signed Medication Authorization form** from the parent or guardian and a properly completed physician's statement.
- School personnel may not give over-the-counter medications unless prescribed by a doctor. A Medication Authorization form must be completed.
- No injectable medications will be given by school personnel except for EpiPen for severe allergic reaction.
- No verbal orders can be taken. Any changes in medication must also be in writing from the physician.
- The authorization by the physician can be on a prescription pad or other form, as long as it has all the information required on the Medication authorization card. It can be attached to the card signed by the parent.
- This card must be renewed each year or if the medication or dosage is changed.
- Medications ordered three times a day or less, unless a time is specified, may not need to be taken at school. The medication should be given before school, after school, and at bedtime.