St. Joseph Montessori School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy** and be labeled with the correct dose and instructions.
    - The label must match what is on the Medication Authorization Form.
    - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
    - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form must be completed.**

  Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, ointments, vitamins and supplements.)

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

- ***All unused medication must be picked up by the parent/guardian on the last day of school. All expired medication will be discarded.***

St. Joseph Montessori School

Asthma Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Student Name_____ School Year_____

Home Address_____ Date of Birth_____ Grade _____

Healthcare Provider to Complete:

Saint Joseph Montessori School urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of_____

Medication_____ Dosage_____ Route_____

Administration Time(s)_____ Beginning Date _____ Expiration Date_____ or end of school year

Instructions and precautions_____

Possible side effects to report to the healthcare provider_____

If the medication does not provide relief_____

Other medications prescribed to this student (home & school) _____

For **asthma inhaler:** The student has demonstrated the proper use of the medication**?** ☐**yes** ☐**no**
The student is capable and may carry and self-administer medication per ORC 3317.716 and 3313.718. ☐**yes** ☐**no**

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's inhaler will be stored in the school medication cabinet to ensure its availability for their use and will have the assistance of trained staff as needed unless he/she is authorized to self-carry and administer.
- If my student is determined capable to self-carry and self-administer by parent, healthcare provider and school nurse, then I authorize my student to carry and use his/her inhaler as prescribed above, at school/school events: ☐yes ☐no. My student is to report to school clinic/office after using medication.
- I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize the School Nurse to communicate with the student's healthcare provider as needed.
- I release and agree to hold the Board of Trustees, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

I give permission for this information to be shared with school staff who supervise my child during the school day.

Parent/Guardian Signature _____ **Date**_____

St. Joseph Montessori School

Asthma Questionnaire

To be completed by parent

Student Name _____ Date of Birth _____ School Year _____

School _____ HR/Grade _____

Parent/Guardian _____ Relationship _____ Phone _____

Parent/Guardian _____ Relationship _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Healthcare Provider _____ Phone _____ Fax _____

The information will provide the school nurse with a better understanding of the child's needs. This questionnaire needs updated and completed each school year.

Has this child been diagnosed with asthma by a healthcare provider? ☐ Yes No

Note: Bring medical documentation to the school nurse. **AFTER** the nurse has received documentation from the child's **healthcare provider,** school staff will be notified of the asthma and emergency plans.

Asthma Triggers - circle and describe:

Exercise Illness Weather Smoke/Fumes/Odors Animal _____ Other _____

Indoor allergies _____

Outdoor allergies _____

Other

Early Symptoms or Warning Signs:

Please list:

Asthma Medicine:

Typically, how often does your child need to use a rescue medication?

How does your child manage an asthma episode at home? ☐ allow to rest and cool down ☐ rescue inhaler ☐ nebulizer ☐ other:

Daily medication name:	**Dosage:**	**When taken:**
"As needed" or rescue medications:	**Dosage:**	**How often:**
☐ Albuterol MDI	90 mcg 2 puffs	
☐ Other		

Any other information or chronic health problems that would be helpful to know?

If the student does not respond to medication during an episode, the school will notify the parent/guardian and call 911.

Parent/Guardian Signature _____ **Date** _____

St. Joseph Montessori School

Authorization for Release of Immunizations and other Health Information

PLEASE RETURN THIS FORM IMMEDIATELY TO THE SCHOOL NURSE.

CHILD'S NAME _____ **DATE OF BIRTH** _____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the Nurse and St. Joseph Montessori School

Obtain Information From:

Please fill in as much as you know

Doctor _____

Clinic _____

Street Address _____

City _____ State _____

Phone _____ Fax _____

Release Information to: St. Joseph Montessori School

Attention School Nurse

Fax: 614-291-7411

Medical Information/Records:

- ☐ **TB skin or TB blood test, chest x-ray report, and medication completion as appropriate**
- ☐ **Immunization record**
- ☐ **Other health information** _____

This authorization will remain in effect for 12 months after the date I sign it. The information released could be further released and no longer protected by privacy regulations. I understand that I may cancel this authorization at any time by sending a written request to the Columbus City Schools at the address above. This request will not apply to information already released.

*I hereby **CANCEL** the authorization as of this date:_____, signed_____.*

This information is requested for school enrollment.

✘ _____ _____

Parent/Guardian Signature Date