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

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Guidelines for Medications at 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 medication cannot be expired.
    - 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.)

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

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AUTHORIZATION FOR RELEASE OF INFORMATION

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 party indicated and Columbus Torah Academy.

Obtain Information From:

Release Information To: Columbus Torah Academy School Nurse
Chris Morford, BSN, RN, LSN
181 Noe Bixby RD
Columbus, OH 43213
(614) 864-0299 ext. 211
cmorford@torahacademy.org

- ○ Medical Information/Records
- ○ TB Test Results/Records
- ○ Immunization Records
- ○ Achievement and Aptitude Test Scores
- ○ Psychological Information/Records
- ○ Grades and Attendance
- ○ Speech and/or Hearing Evaluation
- ○ Individual Education Plan (IEP), if in Special
- ○ Education
- ○ Other Information, as specified: _____

This information to be used for continuity of care.

Parent/Guardian Signature: _____

Date: _____

Electronic signature permitted

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Student Name_____ Date of Birth_____ School Year_____

Home Address_____ HR/Grade

_____

Healthcare Provider to Complete:

Columbus Torah Academy 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)_____ OR ☐ Every _____ hours as needed for_____

Beginning Date _____ Expiration Date_____ /End of school year

Instructions: _____

_____

Precautions and possible side effects_____

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

_____

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 receive the medication as ordered above.
- I understand the medication must not be expired, be in the original container and 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 Columbus Torah Academy staff to communicate with the student's healthcare provider as needed.*
- I release and agree to hold the Columbus Torah Academy Board, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____