benedictine
High School

Medication Permission Request Form

Benedictine High School requires that all students who need medication during school hours must do the following:

1) Present a written consent form signed by the Parent(s) or legal Guardian(s).

2) Bring the medication in the original prescription bottle and properly labeled by a REGISTERED PHARMACIST AS PRESCRIBED BY LAW.

3) This policy also includes "over-the-counter" medication.

Please print the following information:

Student Name_____

Date of Birth_____

TO BE COMPLETED BY A PHYSICIAN:

Name of Medication_____

Time and Dose to be Given at School_____

Length of Time to be Given_____

Are there ANY Restrictions? Yes_____ No_____

If YES, What and for How Long?_____

Printed Name of Physician_____

Signature of Physician_____

Date_____

Parent(s)/Guardian(s) Signature_____

Date_____ Phone Number_____

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Food Allergy Action Plan - Epipen

Student Name_____

Date of Birth_____ Class Year_____

Allergies_____

Please circle one: EPIPEN stored- with son's teacher in Nurse's Office on Self

Son's signs of an allergic reaction:_____

DIAL 911 and EPIPEN is to be administered upon the following symptoms:

- LUNG shortness of breath, repetitive coughing, and/or wheezing
- MOUTH itching and swelling of the lips, tongue, or mouth
- HEART "thready" pulse, "passing out"
- THROAT itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- SKIN hives, itchy rash, and/or swelling about the face or extremities
- STOMACH nausea, abdominal cramps, vomiting, and/or diarrhea

The severity of symptoms can quickly change. All of the above symptoms can potentially progress to a life-threatening situation.

EMERGENCY CONTACTS:

Parent/Guardian Name_____

Phone Number_____

Parent/Guardian Name_____

Phone Number_____

Other Contact Name_____

Phone Number_____

Doctor's Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Ohio Department of Health

Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716/3313.14

A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the 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 student's school is a participant.

Parent/Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Procedures for school employees if the medication does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the physician)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

Physician signature	Date
Physician name	Physician emergency telephone number ( )

Adapted from the Ohio Association of School Nurses