Wadsworth City Schools

524 Broad Street, Wadsworth, OH 44281

Form 5330F1

Phone: 330.336.3571

FAX: 330.335.1313

Building Fax Numbers:

Wadsworth High School	(330.335.1376)	Isham Elementary School	(330.335.1330)
Wadsworth Middle School	(330.336.3820)	Lincoln Elementary School	(330.335.1462)
Central Intermediate School	(330.335.1484)	Overlook Elementary School	(330.335.1425)
Franklin Elementary School	(330.335.1468)	Valley View Elementary School	(330.335.1428)

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The school district requires that all of the following information be provided before it will administer medication or treatment to the student named on this form:

I have prescribed the following medication: _____

_____

Beginning Date: _____ Ending Date: _____

Dosage, instructions, or precautions (including possible side effects): _____

_____

Adverse reactions that should be reported to prescriber: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other condition requiring emergency medication: _____

_____

Authorization for students to self-carry emergency medications:

For student with diabetes:

____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school-sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

____ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school-sponsored events.

For student with asthma:

____ I authorize the student to keep his/her asthma medication in their possession. I have determined the student is capable of correctly self-administering asthma medication.

____ I do not authorize the student to attend to his/her asthma management during regular school hours and school-sponsored events.

For student with severe allergies:

____ I authorize the student to keep his/her EpiPen in their possession. I have determined the student is capable of recognizing the symptoms of anaphylaxis and is able to administer his/her EpiPen.

____ I do not authorize the student to self-carry his/her EpiPen during regular school hours and school-sponsored events.

Prescriber's Signature: _____ Telephone: _____

Printed/Typed Name: _____ Date: _____

Copies must be provided to the principal and the school nurse, if one is assigned to the student's building.

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To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE **PRESCRIBED MEDICATIONS** OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School _____ Grade _____

A. I am requesting permission for my child named above to (check all that apply):

____ use or receive **prescribed medication**.

____ receive **prescribed treatment**.

____ self-administer **prescribed medication(s)** in my presence or that of an authorized staff member.

____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336.

B. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to possess pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

D. 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 from this authorization.

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____