Autism Model School
3020 Tremainsville Rd. Toledo, OH 43613
(419)897-4400
www.AutismModelSchool.com

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Staff of the Autism Model School shall comply with all requirements regarding the Administration of Medications as described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child by school staff shall provide the school with appropriate written authorization(s) and corresponding medications before any medication will be dispersed. **ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, NAME OF THE MEDICATION, DIRECTIONS FOR ADMINISTRATION AND DATE OF THE PRESCRIPTION.** All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order or student's last day of enrollment.

Student Name: _____ Today's Date: _____

Classroom: _____ Date of Birth: _____

----------TO BE COMPLETED BY PHYSICIAN/AUTHORIZED PRESCRIBER----------

Diagnosis: _____

Name of Medication: _____

Dosage: _____ Method: _____ Time(s) of Administration: _____

Medication Administration: Start Date: _____ Stop Date: _____

Is this medication to be self-administered by the child? (Please Circle) **YES** **NO**

Further Instructions: _____

Relevant Side Effects: _____

Side Effect Management: _____

Known Food/Drug Allergies or Reactions: _____

Reaction Management: _____

_____ City/State of Practice: _____
Physician Name (Please Print)

Phone Number: _____

_____ _____ Fax Number: _____
Physician Signature Date

----------TO BE COMPLETED BY PARENT/GUARDIAN----------

By signing below I am requesting that school staff administer medication to my child as described and directed above even when my child is away from school property. I hereby attest that **I have administered at least one dose of the above medication to my child with no adverse effects.**

_____ _____ _____
Parent/Guardian Signature Date Parent/Guardian Name (Please Print)