MARYSVILLE
Exempted Village School District

Board of Education
1000 Edgewood Dr.
Marysville, OH 43040
Office 937-578-6100
Fax 937-578-6113

Early College High School
833 N Maple St
937-578-7300
FAX 937-578-7313

Marysville High School
800 Amrine Mill Rd
937-578-6200
FAX 937-578-6213

Bunsold Middle School
14198 SR 4
937-578-6400
FAX 937-578-6413

Creekview Intermediate
2000 Creekview Dr
937-578-6600
FAX 937-578-6613

Edgewood Elementary
203 Grove St
937-578-6800
FAX 937-578-6813

Mill Valley Elementary
633 Mill Wood Blvd
937-578-6900
FAX 937-578-6913

Navin Elementary
16265 County Home Rd
937-578-7000
FAX 937-578-7013

Northwood Elementary
2100 Creekview Dr
937-578-7100
FAX 937-578-7113

Raymond Elementary
21511 Main St
Raymond, OH 43067
937-578-7200
FAX 937-578-7213

AUTHORIZATION FORM SELF-MEDICATION - ASTHMA INHALERS

(Form MEVS H-3)

This form must be completed by both the physician who prescribes the asthma inhaler and the parent or guardian of the student and delivered to the building principal and clinic staff, if any, assigned to the student's building, prior to the student's self-medication or possession of a metered dose or dry powder inhaler.

PHYSICIAN'S REQUEST (all items MUST be completed)

_____
NAME OF STUDENT – Print DOB

_____
Complete Address Phone

Name of Medication in Inhaler _____ Contains _____doses of medication

Date Self-Administration to Begin (if known) _____ Date Self-Administration to End _____

Instructions/Procedures of school personnel to follow if expected relief from asthma attack is not produced by medication as self-administered: _____

_____

_____

Possible severe adverse reactions:

To Student Self-Administering Medication (to be reported to physician) _____

_____

To children using inhaler for whom it is not prescribed _____

_____

Other Special Instructions _____

_____

Physician's Name (Print) _____

Physician's Complete Address _____

Office Telephone _____ Alternate Emergency Phone No _____

_____
Physician's Signature **Date**

PARENT OR GUARDIAN'S REQUEST

_____
NAME OF STUDENT – Print Building Grade

_____
Complete Address Phone

I_____, parent/guardian of _____
Parent/Guardian – Print Student's Name – Print

Authorize my child to self-administer the medication described on this form as directed by the child's physician. I also agree to comply with Board policy and regulations regarding self-administration of asthma inhaler medication. I also agree to submit to the building principal and clinic staff assigned to my child's school building, if any, a revised authorization if any of the information contained in the Physician's Authorization or on my authorization changes.

I also understand that pursuant to Ohio Revised Code Section 3316.716, the Board of Education and its employees are not liable for my child's self-administration of this medication.

_____ Date: _____
Parent/Guardian's Signature