PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____ is under my care
(Name of Student -- Address)
and should receive _____
(name of drug, dosage, route)
at the following times: _____
(time)
Beginning date: _____

Ending date: _____

Medication will not be administered if any of requested information is omitted or unclear to person(s) authorized to administer medication.

***All prescription medications must be in bottle/package that was prescribed for that specific medication. No zip lock baggies accepted.

Specific instructions for administration:_____
_____

Possible side effects to watch for:_____
_____

***Inhalers carried by students: Ohio Law requires physician to supply information regarding adverse reaction if used by another child. Adverse reactions include:_____

Date:_____ _____
Physician's Signature

_____
Physician's phone number

* * * * * * * * * * * * * * * * * *

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his delegate (other responsible person) to administer the following medication to my child.

Name of Child _____
Grade/Teacher

Name of Drug _____ Dosage_____

Route _____ at the following times:_____

Date_____

PERSON WHO WILL ADMINISTER MEDICATION IN SCHOOL:_____

It is the obligation of the parent, guardian or person having care of the child to provide a written, revised statement signed by a physician (if prescription medicine) if the information given above should change

I have read and understand the condition of this request and verify that the above information has been accurately provided. I hereby give permission for the school designated to administer medication to my child.

Parent/Guardian Signature_____