Please note: We are not permitted to pass out medications without parent permission.
If your son/daughter needs medication during the school day it must be furnished by the parent or guardian and must be stored in the office.

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

This form is to be used for students attending Anna Local, Botkins Local, Fairlawn Local, Fort Loramie Local, Hardin-Houston Local, Jackson Center Local, Russia Local, Cooperative Learning Center, and Sidney City Schools.

PHYSICIAN: PLEASE COMPLETE

Student's Name: _____ Date of Birth: _____

Address: _____ School District: _____

City: _____ State: _____ Zip: _____

The above named student is under my care and should receive:

Name of Drug: _____

Why should this drug be administered at school?:

_____

Dosage: _____ Times: _____

Special instruction for administration:

_____

Side effects to watch for: _____

Beginning Date of Requests: _____ Expiration Date of This Request: _____

Physician's Phone Number: _____ Physician's Signature: _____ Date: _____

_____

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

I hereby request and give my permission to the principal or a designee (secretary, teacher, or other responsible person) to administer the following medication to my child:

Name of Child: _____ School: _____ Grade: _____

Name of Drug: _____ Dosage: _____

At the following time(s): _____

Beginning _____ and until _____
Date Expiration Date

_____ _____ _____
Parent's Phone Number Signature of Parent or Guardian Date

NOTE: THE PARENTS OF THE CHILD MUST ASSUME RESPONSIBILITY FOR INFORMING THE PRINCIPAL OF ANY CHANGE IN THE CHILD'S HEALTH OR ANY CHANGE IN THE PRESRIBED MEDICATION. ANY CHANGES TO THE ABOVE PRESCRIPTION (DOSAGE OR ADMINISTRATION) WILL REQUIRE THE COMPLETION OF A NEW FORM. PARENTS <u>MUST</u> SEND MEDICATION TO SCHOOL IN ITS <u>ORIGINAL</u> CONTAINER.

_____ _____
School Official's Signature (Acknowledging Receipt) Date