**OLENTANGY** | LOCAL SCHOOL DISTRICT

# PHYSICIAN'S MEDICATION PROCEDURE REQUEST FORM

(This form MUST be typed or printed legibly)

TO BE COMPLETED BY THE PHYSICIAN

Child's Name ______________________ Birth Date ____________

Child's Address ______________________

Diagnosis ______________________

Prescribed Medication ______________________

Dosage or Procedure Required ______________________

Time Required ______________________

Can a morning dose be given if forgotten at home? ______________________

What is the morning dose? ______________________

Should afternoon dose be adjusted? ____________ New Time ____________

Possible adverse reactions, which should be reported to the parent and physician:

______________________

______________________

Special instructions for administration (including students carrying own meds, storage or sterile requirements): ______________________

Date when administration of medication or procedures is to begin: ____________

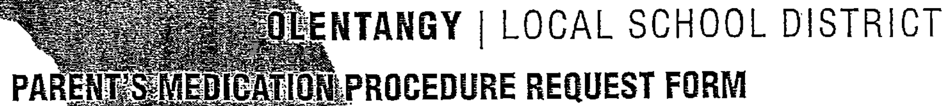
Date when administration of medication or procedures is to end: ____________

Physician's Signature: ______________________

Physician's Name: ______________________

Physician's Address: ______________________

Physician's Telephone/Fax Number: ______________________




Student's Name ______________________ Grade Level ________

As parent or legal guardian of the above named student, my signature below authorizes school personnel to administer the medication or procedure to my child as instructed on the "Physician's Medication Procedure Request Form." I understand that a trained staff member administering the medication might not be a health professional. My signature further indicates that I agree to:

1. Deliver the medication to the building principal or office secretary in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
2. Notify the building principal of a change in physicians.
3. Notify the building principal in writing if the medication, dosage, procedure or any information is changed or is to be eliminated.
4. If requested discuss with school officials the effect of the medication or procedure given at school; further, school officials are hereby authorized to contact the physician on matters relating to the medication.
5. Release any claims against the Board of Education or its employees arising from the administration of medication in accordance with this request.

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PARENT'S STATEMENT

I have read the above statements and agree to them.

Parent's Signature ______________________ Date ________

PRINCIPAL'S STATEMENT

Principal's Signature ______________________ Date ________

I assign the administration of the medication to:

______________________

(School Secretary, Principal, Teacher, Office Aide, School Nurse)