Physician's Request for the Administration of Medication by School Personnel.

_____ is under my care and should receive _____
(Name of Student) (Name of Drug, Dosage)

at the following times _____. Specific instructions for administration or storage _____.

Possible reactions to watch for and report to physician _____.
Expiration date of this request: _____.

_____ _____
Date Physician's Signature

_____
Address
( )_____
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 (School nurse or other responsible person) t administer the following medication to my child. My signature releases the Board of Education, its employees an representatives of all liabilities with the administration of medication. The actual/original prescription/medicatio container ***MUST*** *be sent to the school.*

Name of child _____
Name of Drug _____ Dosage _____
at the following time(s) _____

Parent agrees to notify the person responsible for administering medication of the following:

1. Any change in physician.
2. Delivery of medication or new medications to the school.
3. Any change in medication or procedures.

_____ _____
Signature of person administering medication Building Principal

(____)_____
_____ _____ Phone No. where you
Date Signature of parent or guardian can always be reached

RETURN ENTIRE FORM TO THE SCHOOL - BOTH AREAS MUST BE COMPLETED

ADOPTED: December 12, 1983
ADOPTED: March 12, 1990
ADOPTED: March 12, 1999

BELLAIRE LOCAL SCHOOL DISTRICT, BELLAIRE, OHIO 43906-1513

NURSE: MEDIFRM