

# BUCKEYE LOCAL SCHOOLS

## ADMINISTERING MEDICATION PRESCRIBED BY A PHYSICIAN

### STATEMENT OF PHYSICIAN FOR MEDICATION TO BE ADMINISTERED BY SCHOOL EMPLOYEES

(R.C. 3313.713)

(NOTE: all blanks **MUST** be filled in)

Name of student

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Address of student

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School and class in which  
the student is enrolled

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Name of medication

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Dosage to be administered

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Time or intervals at which  
each dosage is to be  
administered

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Date the administration of  
the medication is to begin

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Date the administration of  
the medication is to cease

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Any severe adverse reactions  
that should be reported to the  
physician

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One or more telephone numbers  
at which the physician can be  
reached in an emergency

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Special instructions for  
administration of the medication,  
including sterile conditions and  
storage

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**Name of physician**

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**Address of physician**

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**Date of this statement**

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**Signature of physician**

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**STATEMENT OF PHYSICIAN  
FOR MEDICATION TO BE ADMINISTERED  
BY SCHOOL EMPLOYEES**

(R.C. 3313.713)

I am the parent, guardian, or other person having care or charge of

\_\_\_\_\_, who is a student assigned to  
\_\_\_\_\_ and request that the medication described on the  
attached statement of the prescribing physician be administered to him/her.

I specifically agree that if any information on the attached Physician's Statement changes I will immediately submit to the school nurse or building principal a revised statement completed and signed by the prescribing physician. Any school employee administering the medication described on the statement of the prescribing physician shall be entitled to rely upon the information therein contained until such time as a revised statement is submitted.

**DATE** \_\_\_\_\_

**NAME OF PARENT** \_\_\_\_\_

**SIGNATURE OF PARENT** \_\_\_\_\_