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 ________________________________

Address of student ________________________________

School and class in which the student is enrolled ________________________________

Name of medication ________________________________

Dosage to be administered ________________________________

Time or intervals at which each dosage is to be administered ________________________________

Date the administration of the medication is to begin ________________________________

Date the administration of the medication is to cease ________________________________

Any severe adverse reactions that should be reported to the physician ________________________________

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

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

Name of physician ________________________________

Address of physician ________________________________

Date of this statement ________________________________

Signature of physician ________________________________

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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 ____