PHYSICIAN'S/PARENT'S REQUEST FOR THE ADMINISTRATION OF <u>PRESCRIBED MEDICATION</u> BY SCHOOL PERSONNEL

Student Name______________________________School____________________Grade_____

Address___________________________________Date of Birth________Date____________

TO BE COMPLETED BY PHYSICIAN:

*One Medication Per Form.

Name of Medication____

Time(s) to be given___________________________________ (during school hours)

Time(s) to be given_____________________________________ (non-school hours, field trips)

Dose ____

Form of Medication: ____Tablet/capsule ____ Liquid ____Inhaler ____Nebulizer ____Other

Start Date_________________________ Stop Date __________________________

Severe reactions to be reported to the Physician:_______________________________

Date_____________ Physician's Signature_________________________

Physician's Phone________________ Physician's Name Printed______________________

TO BE COMPLETED BY PARENT / LEGAL CUSTODIAN / GUARDIAN / GRANDPARENT

I give permission for my child to receive medication at school or on a field trip according to the District's Policy and as instructed by the prescribing physician and I agree to:

* Assume responsibility for safe delivery of the medication to the school.
* Have a new form completed by the physician if medication or dosage is changed.
* Notify the school of prescribing physician changes.

Date_____________

Parent / Legal Custodian / Guardian / Grandparent Signature_________________________

Daytime Phone Number ________________

Fax to: Mogadore Jr High/High School 330-628-6657 / O.H. Somers Elementary 330-628-6662

This form will expire at the end of the school year