PHYSICIAN'S/PARENT'S REQUEST FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION 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