

PROCEDURE FOR ADMINISTRATION OF MEDICATION
(IN ACCORDANCE WITH O.R.C. 3313.713)

DATE _____

GRADE _____ TEACHER _____

NAME OF STUDENT _____

MY CHILD MAY BE GIVEN THE INDICATED MEDICATION BY PROPERLY DESIGNATED SCHOOL PERSONNEL DURING SCHOOL HOURS.

ADDRESS _____

SIGNATURE OF PARENT OR GUARDIAN

PHONE @ HOME _____ WORK _____

SIGNATURE REQUIRED FOR PRESCRIPTION OR NON-PRESCRIPTION MEDICATION
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NAME OR DESCRIPTION OF MEDICATION OR PROCEDURE _____

DOSAGE AMOUNT & NUMBER OF TIMES _____

TIME MEDICATION TO BE GIVEN AT SCHOOL _____

DATE ADMINISTRATION OF DRUG BEGINS _____ AND ENDS _____

SEVERE REACTIONS THAT SHOULD BE REPORTED TO THE PHYSICIAN _____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF THE DRUG OR ANY OTHER PROCEDURE

SIGNATURE OF ATTENDING PHYSICIAN _____

(FOR PRESCRIPTION MEDICATION ONLY)

ADDRESS _____

PHONE _____

***NOTE**
THE MEDICATION MUST BE RECEIVED
IN THE CONTAINER IN WHICH IT WAS
DISPENSED BY THE PRESCRIBING PHYSICIAN
OR LICENSED PHARMACIST. NON PRESCRIPTION
MEDICATION WILL NOT BE GIVEN BY THE SCHOOL
WITHOUT WRITTEN PERMISSION BY THE PARENT OR
GUARDIAN.

FILL OUT THIS FORM ONLY IF YOUR CHILD NEEDS TO TAKE MEDICATION. THE DOCTOR MUST ALSO FILL OUT THIS FORM IF IT IS PRESCRIPTION MEDICATION.