HEATH CITY SCHOOLS
PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

PART A: TO BE COMPLETED BY THE PHYSICIAN

_______________________________ (Name of Student) _____________________________________ (Address)

is under my care and should receive ____
(Name of drug, dosage, and route)

at the following time(s) ____

Specific instructions for administration ____

____

Possible side effects to watch for ____

_____________________________ (Date administration is to begin) _____________________________ (Date administration is to cease)

_____________________________ (Physician's Signature) _____________________________ (Physician's Name Printed)

____
(Physician's Phone Number and Address)

PART B: TO BE COMPLETED BY THE PARENTS OR GUARDIANS

I request authorized school personnel to follow the medical instructions requested in PART A. I agree to see that the medication is delivered to the school; to notify the school if there is a change in physician; to notify the school if medication, dosage, or procedure is changed or discontinued. I give my consent to the physician, school nurse or their designees to send and/or receive information related to my child's health as they deem appropriate for the duration of this order as noted above.

DATE ___________________ SIGNATURE ____
(Parent or Guardian)

Required by Ohio Revised Code 3313.203, 3313.56, 3313.671, 3313.712, 3313.713

Please Note: Both sections of this form must be completed before any medication can be given at school.

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