

**OLENTANGY | LOCAL SCHOOL DISTRICT**

**PHYSICIAN'S MEDICATION PROCEDURE REQUEST FORM**

(This form MUST be typed or printed legibly)

TO BE COMPLETED BY THE PHYSICIAN

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Child's Address \_\_\_\_\_

Diagnosis \_\_\_\_\_

Prescribed Medication \_\_\_\_\_

Dosage or Procedure Required \_\_\_\_\_

Time Required \_\_\_\_\_

Can a morning dose be given if forgotten at home? \_\_\_\_\_

What is the morning dose? \_\_\_\_\_

Should afternoon dose be adjusted? \_\_\_\_\_ New Time \_\_\_\_\_

Possible adverse reactions, which should be reported to the parent and physician:

\_\_\_\_\_  
\_\_\_\_\_

Special instructions for administration (including students carrying own meds, storage or sterile requirements): \_\_\_\_\_

Date when administration of medication or procedures is to begin: \_\_\_\_\_

Date when administration of medication or procedures is to end: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Telephone/Fax Number: \_\_\_\_\_

**OLENTANGY | LOCAL SCHOOL DISTRICT**  
**PARENT'S MEDICATION PROCEDURE REQUEST FORM**

Student's Name \_\_\_\_\_ Grade Level \_\_\_\_\_

As parent or legal guardian of the above named student, my signature below authorizes school personnel to administer the medication or procedure to my child as instructed on the "Physician's Medication Procedure Request Form." I understand that a trained staff member administering the medication might not be a health professional. My signature further indicates that I agree to:

1. Deliver the medication to the building principal or office secretary in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
2. Notify the building principal of a change in physicians.
3. Notify the building principal in writing if the medication, dosage, procedure or any information is changed or is to be eliminated.
4. If requested discuss with school officials the effect of the medication or procedure given at school; further, school officials are hereby authorized to contact the physician on matters relating to the medication.
5. Release any claims against the Board of Education or its employees arising from the administration of medication in accordance with this request.

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**PARENT'S STATEMENT**

I have read the above statements and agree to them.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PRINCIPAL'S STATEMENT**

Principal's Signature \_\_\_\_\_ Date \_\_\_\_\_

I assign the administration of the medication to:

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(School Secretary, Principal, Teacher, Office Aide, School Nurse)