Student Medication Request Form

(For Prescription and Non-Prescription Medications)

Orrville City Rittman Exempted Village Wooster City Wayne County School Districts

School: _____ Student's Name: _____

School Year: _____ Date of Birth: ____/____/____

Class/Teacher: _____

To Be Completed By Prescribing Physician

_____ of _____ is under my care and
(Student's Name) *(Address)*

should receive _____
(Name of Drug) *(Dosage)* *(Method)*

at the following times: _____

Date administration of drug is to begin: _____ and end: _____

Severe or adverse reactions, which should be reported to the doctor: _____

_____

Special instructions for administering the drug: _____

Storage requirements or sterile conditions required for the drug: _____

_____

Should a change in any of the above information occur, a revised written physician's statement must be submitted to the school.

_____
(Physician's Printed Name) *(Physician's Signature)* *(Date)* *(Physician's Phone Number)*

To Be Completed by Parent or Guardian

I hereby request and give my permission to the principal or his designee (e.g., school nurse or other responsible Board authorized person) to administer the above medication to my child as instructed by the physician.

All medication must be brought to the school in the original container as dispensed by the pharmacist or physician, clearly labeled. Ask the pharmacist to give you two containers. Send only the amount of medication that will be administered during school hours. Medications will be kept in the clinic/office.

If any revisions in the above plan or doctor's statement occur, a written revised doctor's statement must be submitted to the school. (It is understood that it is the student's responsibility to seek the medication at the proper location and time unless he/she is physically or mentally unable to do so.)

_____
(Parent/Guardian's Signature) *(Date)* *(Parent/Guardian's Phone Number)*

School Use: Date Received: _____ Initialed By: _____