

OLENTANGY SCHOOLS

PHYSICIAN'S MEDICATION PROCEDURE REQUEST FORM

TO BE COMPLETED BY THE PHYSICIAN

Child's Name _____ Birth Date _____

Child's Address _____

Diagnosis _____

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):

Date when administration of medication or procedure is to begin: _____

Date when administration of medication or procedure is to end: _____

Physician's Signature: _____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone Number: _____

Physician's Fax Number: _____

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PARENT'S MEDICATION PROCEDURE REQUEST FORM

Student's Name _____ Grade Level _____

As a parent or legal guardian of the above named child, my signature below authorizes school personnel to administer the medication as instructed by the physician. I understand that a trained staff member administering the medication might not be a health professional.

1. I will deliver the medication to the clinic staff in its original container.
2. I will notify the clinic staff immediately if there is any change in the use of this medication or the prescribed treatment.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for the damages or injury resulting directly or indirectly from this authorization.
4. I agree that school officials are authorized to contact the physician on matters relating to the medication.
5. I agree that this form is in effect for the duration of the current school year unless stated below.
6. I have read the above statements and agree to them

Parent's Signature(s)

Date Signed

Principal's Signature

Date Signed

NF 7/15/2019 Revised