Reynoldsburg City Schools
Parent's Request for the Administration of Prescription Medication at School

To be completed by the parent:

I request the school nurse, building principal, or designee, to administer the medication named on this form and prescribed by the signing physician to my child,

_____at_____
CHILD'S NAME SCHOOL NAME

Further, I agree to:

1. Ask the physician if it is necessary to give the medication during school hours.
2. Deliver the medication personally to the school in the ORIGINAL container in which it was dispensed, properly labeled to include the name of the student, physician, date, dosage instructions (quantity and time) and the name of the medication.
3. Notify the school if my child changes physicians or if the medication, the dosage, or the procedure is changed or eliminated.
4. Hold the school or school personnel harmless for the administration of the medication described since the school personnel are not legally obligated to administer medication to any child.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

_____ _____ _____
ADDRESS OF PARENT/GUARDIAN HOME PHONE WORK PHONE

**If parents are separated and both still retain custody, *both* must sign. If child is under the care of an agency, a representative from that agency must sign.

TO BE COMPLETED BY THE SCHOOL:

1. Nurse's Signature: _____Date: _____
2. Principal's Signature: _____Date: _____
3. Designee's Signature: _____ Date: _____
4. Date and Type of Training to administer medication if necessary:

   _____

Reynoldsburg City Schools
Physician's Request for the Administration of Medication at School

To be completed by the Physician:

I, the undersigned physician, am certifying that medication for the student listed below cannot be scheduled for other than school hours. Further, I realize that the administration of such medication may be supervised by medically untrained personnel. I am aware that the medication must be sent to school in the ORIGINAL container in which it was dispensed and that no medication will be administered at school unless items 1-11 below are completed.

1. Student's name: _____

   Grade and Teacher: _____

2. Student's Address: _____

3. Name of Medication: _____

4. Diagnosis: _____

5. Dosage to be Administered: _____

6. Times or intervals for each dose to be given: _____

7. Date to start administration: _____

8. Date to end administration: _____

9. Any severe adverse reactions which should be reported to the doctor: _____

   _____

10. Any special instructions for administering or storing the medication: _____

    _____

11. Physician's Identifying Data:

PHYSICIAN'S NAME IN PRINT PHYSICIAN'S SIGNATURE

PHYSICIAN"S ADDRESS DATE