FINDLAY CITY SCHOOLS
2019 Broad Ave.
Findlay, Ohio 45840

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

_____ _____
(Name of Student) (Address)

_____ _____
(School attended) (Grade)

is under my care and should receive

_____ at school under the following instructions:
(Name of Drug)

Dosage (times or intervals drug is to be administered: _____
_____
_____

Special/specific instructions for administration including sterile conditions and storage:

_____
_____

Possible severe adverse reactions: _____
Date administration of drug is to begin: _____
Expiration date of this request: _____
Date: _____
(Physician's Signature)

_____ _____
(Physician's Address) (Physician's Phone Number)

_____
(Physician's Emergency Phone Number)

PARENTS REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his/her designee (employees who have received the training required in O.R.C. 3313.713) to administer the medication as indicated by the above physician's request to my child. Name of child _____.

I understand that the parent should administer this medication whenever possible and that the medication must be in a proper container, labeled by the pharmacist or physician.

By this request, I voluntarily, on behalf of the child herein named and myself, release the principal and/or his/her delegate from any and all liability for civil damages arising out of or from the administration or the failure to administer the medication in the above physician's request.

Date: _____
(Signature of Parent)

_____
(Address)

Revised 6/8/98
Reviewed 6/13/05
Revised 12/12/11
Reviewed 6/18/12
Reviewed 8/27/13
Revised 8/7/2017