

FINDLAY CITY SCHOOLS  
1100 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)