



PHYSICIAN'S INSTRUCTIONS FOR THE ADMINISTRATION OF MEDICATION ON SCHOOL PREMISES

Note to MSMV Parents: Please keep this form on hand to take to the doctor at any point during the school year when your child needs medical attention. If the physician determines your child will need medication administered during school hours, please have him/her complete this form. Please return this form in person, along with the medication in its original packaging to the school office for administration. Medication, other than an asthma inhaler, should never be sent to school in a backpack or lunchbox, or in a child's possession.

Name of Student

Address

_____ in _____ at MSMV, is under my care and should receive the

Date of Birth

Class/Grade

following medication according to the following instructions:

- 1) Name of medication: _____
- 2) Purpose of medication: _____
- 3) Dosage: _____
- 4) Time to be administered: _____
- 5) Date to begin AND duration: _____
- 6) Severe adverse reactions: _____
- 7) Termination date for administering medication: _____
- 8) Other instructions or comments: _____
- 9) Procedure to follow in the event that the medication does not produce relief : _____

This student is able / unable to administer such medication without adult monitoring or assistance.

Date

Physician's Signature

Physician's Phone Number

Parent's Request for the Administration of Medication on School Premises

I request that the above medication be administered as instructed by my child's physician/dentist. I understand that a new form must be submitted each school year and whenever the medication or dosage is changed. I am required by Ohio law to provide the school with the medication in the original container as dispensed by the pharmacy.

I release and agree to hold harmless the Board of Trustees, its officials, and its employees from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Date

Parent/Guardian's Signature

Parent Emergency Daytime Phone