FIRELANDS LOCAL SCHOOL DISTRICT

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

This form ***must*** be **filled out, signed, and returned** to your child's school **before** medication will be administered in school.

STUDENT'S NAME: _____ DATE: ____/____/____

STUDENT'S ADDRESS: _____ PHONE: _____

BUILDING (circle one): **FES** **SAMS** **FHS** GRADE/TEACHER: _____

Physician's order for medication in accord with 3313.713 Ohio revised code.

MEDICATION TO BE ADMINISTERED: _____

DOSAGE: _____ TIME/S OF DAY TO BE TAKEN: _____

STARTING DATE OF THIS REQUEST: ____/____/____ TERMINATION DATE: ____/____/____

SPECIAL INSTRUCTIONS (IF ANY): _____

POSSIBLE REACTIONS OR SIDE EFFECTS: _____

_____

PHYSICIAN'S SIGNATURE: _____ WORK/HOME PHONE: _____

PARENT SIGNATURE: _____ WORK/HOME PHONE: _____

REMINDER: All medication must be provided in original container as dispensed by the physician or pharmacist.

(Adoption date - Oct. 14, 1986 -
Revised: July 11, 1994)

Firelands Local School District
Oberlin, Ohio