VALLEY MIDDLE SCHOOL

393 Indian Drive
Lucasville, Ohio 45648

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2018 – 2019

Aaron Franke
Principal

Jeff Rase
Guidance Counselor

Administering Medication at School

PHYSICIAN'S STATEMENT

(As required by Ohio Law)

This form must have every item completed or the medication will not be administered by school personnel.

TO BE COMPLETED BY YOUR PHYSICIAN

NAME OF STUDENT: ____

ADDRESS OF STUDENT: ____

SCHOOL: **Valley Middle School** GRADE: _______

NAME OF MEDICATION: ____

DOSAGE OF MEDICATION: ____

TIME OF DOSAGE: ____

DATE DRUG IS TO BEGIN: __________________________ AND END: ____________________________

ANY SEVERE REACTIONS THAT SHOULD BE REPORTED TO THE PHYSICIAN:

____

____

SPECIAL INSTRUCTIONS: ____

____

If self-medication has been prescribed, please answer the following questions:

Has the student received instruction in self-administration of this medication? ___ Yes ___ No

Do you feel this student is qualified to self-administer this medication? ___ Yes ___ No

Physician Signature	**Physician Printed Name**	Date	Telephone Number

Important Information

The parent or guardian agrees to submit a revised statement signed by the physician if any of the information originally provided by the physician changes.

The medication is received by school authority in the container in which it was dispensed by the prescribing physician.

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give my permission for my child, ____________________________, to be administered the above prescription drug as prescribed by his/her physician.

Parent/Guardian Signature	Date