MEDICAL DEPARTMENT
MIAMISBURG CITY SCHOOLS
Sixth Street at Park Avenue, Miamisburg, Ohio 45342
937/866-3381
Fax: 937/865-5250

PHYSICIAN PERMISSION FOR ADMINISTRATION OF MEDICATION TO STUDENTS

The following student is under my care and should receive the medication indicated below. Since it is not possible to arrange for this medication to be taken at home under parent supervision, it is requested that it be administered at school.

Name of Student:_____Grade:_____ School:_____

Address of Student: _____

_____

Name of prescribed medication, dosage and method of administration:_____

_____

Times and intervals medication is to be administered: _____

_____

Severe adverse reactions that should be reported to the physician: _____

_____

Special instructions for administration of medication: _____

_____

Date:_____ Physician's Signature_____

Physician's Name and Telephone Number_____

_____

***ONE MEDICATION PER FORM
***ANY REVISION TO PHYSICIAN'S PRESCRIPTION REQUIRES A NEW FORM
***PARENT AGREES TO NOTIFY SCHOOL NURSE OF ANY REVISION OF PHYSICIAN PRESCRIPTION

TO BE COMPLETED BY SCHOOL

Person(s) authorized to administer medication for this student. Principal should list name(s).

_____ _____

_____ _____

Nurse's Signature_____ Date _____

Principal's Signature _____ Date _____

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PARENT/GUARDIAN PERMISSION FOR ADMINISTRATION OF MEDICATION TO STUDENTS

The parent or guardian who has custody of the student must sign this release. If the student is in a foster home and placement is by an agency that holds custody, the agency must sign.

I hereby request, authorize and give my consent to the principal or his delegate (school nurse or other trained person) to store and administer the following medication for my child.

Student Name: _____

Student Address: _____

Name of Prescribed Medication: _____

Dosage and Time(s) to be Administered: _____

I release Miamisburg City Schools and all employees from any liability or damages resulting from the consequences or adverse reactions of my child's taking, or failing to take, this medication at the time prescribed. I also understand that if the medication dosage or time of administration is changed, I must submit a new "Physician Permission" form indicating the change. I also acknowledge that all medication must be in the original container in which it was purchased.

Date_____ Parent/Guardian Signature _____

Home Telephone Number _____

Work Telephone Number _____

Physician Name and Number _____

_____

_____