PERRY LOCAL SCHOOLS

Statement Of Prescriber
For Medication To Be Administered By School Employees
(O.R.C. 3313.713)
NOTE: **ALL** Blanks Must Be Filled In

______________________________ ______________________________
Name of student Allergies

______________________________ , OH ______________
Address City Zip

School: (circle one) Elementary School ~ Middle School ~ High School

Grade level: __________ Teacher: ____________________ Age of student: __________

Name of medication: ______________________________

Dosage to be administered: ______________________________

Time or intervals at which each dosage is to be administered: ______________________________

____

Date the administration of the medication is to begin: ______________________________

Date the administration of the medication is to cease: ______________________________

Any severe adverse reactions that should be reported to the prescriber:

____

One or more telephone numbers at which the prescriber can be reached in an emergency:
____

Special instructions for administration of the medication, including sterile conditions and storage: ______________________________

Name of prescriber: ______________________________

Address of prescriber: ______________________________

Date of this statement: ____________________ Diagnosis: ____________________

Signature of prescriber: ______________________________

Name of prescriber (print): ______________________________

STATEMENT OF PARENT/GUARDIAN REQUESTING THAT SCHOOL EMPLOYEES ADMINISTER MEDICATION TO STUDENT (O.R.C. 3313.713)

I, ______________________________, am the parent, guardian or other person

having care or charge of _________________________________, who is a student at:

Elementary School ~ Middle School ~ High School
(circle appropriate school).

I hereby request and give my consent that the medication described on the attached statement of the prescriber be administered to him/her by any employee of the Board of Education who has been duly authorized by the Board to administer medication to students.

I further agree that any school employee administering the medication described on the statement of the prescriber shall be entitled to rely upon the information therein contained until such time as a revised statement is submitted.

I further specifically agree that if any information on the attached Prescriber's Statement changes I will immediately submit to the school nurse/health associate or building principal a revised statement completed and signed by the prescriber.

Date: _____________________

Signature of parent/guardian: __________________________________

Name of parent/guardian: __________________________________

Name of medication: __________________________________

Daytime phone number: __________________________________

NOTE

The reverse side of this form (Statement of Prescriber for Medication to be Administered by School Employees) must be completed by the student's prescriber.

FOR SCHOOL OFFICE USE ONLY

This medication request form has been properly completed by both the physician and the parent/guardian and the medication will be administered by authorized school employee(s).

____
Principal / School Nurse or/ District Nurse