MINFORD LOCAL SCHOOL DISTRICT
Administration of Medication
Physician's Statement
(As Required by Ohio Law)

This form must have every item completed or the prescription cannot be administered by school personnel.

Student's Name _____ Date _____

Student's Address _____ City _____

School _____ Grade _____

Name of Prescription and Dosage_____ Time of Dosage _____

Date Drug is to begin _____ And end _____

Any severe reactions that should be reported to the physician:

Special instructions: _____

_____ _____
Physician's Signature Physician's Phone Number & Date

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 drug must be received by school authority in the container in which it was dispensed by the prescribing physician or licensed pharmicist.

Parent or Guardian Request

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

_____ _____
Parent or Guardian Signature Address