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 pharmacist.

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