

WESTERVILLE CITY SCHOOLS

REQUEST TO ADMINISTER PRESCRIBED MEDICATION TO A STUDENT DURING SCHOOL HOURS

As Required By Section 3313.713 Ohio Revised Code

Student Name: _____ Date of Birth: _____

Student Address: _____

School: _____ Grade: _____ Teacher: _____

PARENT SECTION

- 1. This form must be completed by both the parent (top section) and the prescriber (bottom section)
2. Medication must be kept in the student's prescription labeled bottle.
3. Deliver no more than 2 -4 weeks supply of medication to school clinic staff directly by the parent/guardian
4. A revised statement signed by the prescriber must be provided for any changes.

When possible, give medication outside of school hours. *CONSENT : I, give consent for School Staff to make direct contact with the prescriber should an emergency adverse reaction indicated below occur.

Signature of parent: _____ Date: _____
Parental signature authorizes school personnel to administer the below prescribed medication.

Parent phone number: _____ Day time _____ Evening _____

PHYSICIAN SECTION

I verify that this medication must be taken by: _____ Name of Student

FOR DAILY MEDICATIONS (When possible, please attempt to schedule medication outside of school hours)

Table with 4 columns: DRUG, DOSE, ROUTE, TIME TO BE GIVEN

FOR AS NEEDED MEDICATION

Table with 4 columns: DRUG, DOSE, ROUTE, TIME INTERVAL BETWEEN DOSES

Diagnosis for which medication is prescribed?
Any severe adverse reactions that should be reported to the prescriber *?
Special instructions for administration, including sterile conditions and storage?
Start date to administer at school: Expiration date:

X
Prescriber's Signature _____ Date _____

Prescriber's Printed Name: _____ Phone: _____

Prescriber's Address: _____

If faxed to school, it is the parent's responsibility to ensure it is received FAX NUMBER: _____