PHYSICIAN'S REQUEST
FOR THE ADMINISTRATION OF MEDICATION
BY TROY CITY SCHOOLS PERSONNEL

Rev 5.12

All parents who wish to have any type of medication including non-prescription drugs and cough drops administered to their elementary school age child (Grades K through 6) must submit to the school written authorization signed by both the parent and the physician. This form is available from the school clinic/office/website.

This form is to be used for a drug prescribed by a physician for all students (Grades K through 12). We apologize for any inconvenience this might cause, but with widespread concern over the abuse of drugs and the need to insure that all medications are administered correctly and as intended, we must ask your cooperation in complying with this state law (OHIO REVISED CODE Section 3313.713).

Along with the permission form signed by the physician and the parent, we need the medication to be in the original container with a label on it.

PHYSICIAN'S REQUEST
FOR THE ADMINISTRATION OF MEDICATION
BY TROY CITY SCHOOLS PERSONNEL

PART I

Pupil's Name _____ School _____

Pupil's Address _____ Grade _____ Date of Birth _____

is under my care and should be administered the following drug: Diagnosis: _____

Name of Drug _____ Times or Intervals _____

Dosage _____ Special Instructions for Administration _____

Beginning on (date) _____ and ending on (date) _____

Possible severe adverse reactions that should be reported to the physician:

_____

At (phone number): _____ Fax: _____

Physician's Signature _____ Name _____

Date _____ Address _____

PART II — TO BE COMPLETED BY PARENT OR GUARDIAN

We (I) understand that the administration of this medication is to be done under the supervision of the School Nurse with an authorized adult school staff person giving the medication.

Further, we (I) understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) agree to release and waive all claims against the School District and its employees from any and all liability for bodily injury or death resulting from such medication or the manner in which it is administered.

Further, we (I) agree to deliver the medication to the school in the original container from the prescribing physician or licensed pharmacist, properly labeled by same. This label to include name of student, physician, date, dosage instructions (quantity and times) and name of medication.

Further, we (I) will notify the school immediately if we change physicians or medication or terminate the use of this medication for any reason.
Further, we (I) give consent for the school nurse/clinic assistant to communicate with the physician's office in regard to this medication order.

Signature of Father, Mother or Guardian _____ Date _____