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

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 ____________________

THE TROY SCHOOLS
SCHOOL HEALTH EXAMINATION RECORD
PHYSICIAN FORM – PART II

STUDENT NAME: ______________________________ **DATE OF BIRTH:** ______________

TO BE COMPLETED BY PHYSICIAN: (Or Attach Copy of Immunization Record)

IMMUNIZATIONS					
	Date #1	Date #2	Date #3	Date #4	Date #5
DTap					
DT					
POLIO					
MMR (Measles, mumps, rubella)					
HIB-V					
HEPATITIS-B					
VARICELLA (Chicken Pox) (2)					
OTHER					

PHYSICAL EXAMINATION: To be filled in and signed by physician:

Date: ________ **Age:** ________ **Height:** ________ **Weight:** ________

GENERAL APPEARANCE, NUTRITIONAL STATE	REMARKS CONCERNING ANY ABNORMAL FINDINGS:
Posture	
Skin	
Eyes	
Ears	
Nose	
Throat (tonsils)	
Mouth (teeth, etc.)	
Neck	
Heart	
Blood Pressure	
Lungs	
Abdomen	
Genitalia	
Hernia	
Neurological	
Emotional	

May carry full Physical Education Program? Restricted Physical Education Program? Explain:

Special Tests (at doctor's discretion)

Urinalysis ______________________________

Hemoglobin ______________________________

Tuberculin ______________________________

Other ______________________________

What medication, if any, is the child taking?

Physicians Report of Health Findings: [ ] Entirely within normal limits [ ] Abnormalities as follows:

Recommendations for adjustment in school program, including participation in sports activities:

Date: ______________ **Signature of Examining Physician:** ______________________________

Typed or Printed Name of Examining Physician: ______________________________

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