PARENT OR GUARDIAN REQUEST TO ADMINISTER MEDICATION

As the parent or legal guardian of_____ who attends _____School, I request that my child be given the medication described below as prescribed by Dr_____. I understand that this medication will be given by the principal or his/her designee. I also understand that I must submit a revised statement signed by the physician if any of the information originally provided by the physician changes.

1. All medication must be brought to school by parent/guardian.
2. All medication must be received in the original prescription bottle properly labeled by a registered pharmacist as prescribed by law. All medication must be labeled with the student's name, dosage, and the name of the medication.
3. Nonprescription medication (over the counter) will not be administered within the schools by school personnel except with doctor's written orders.

_____ _____

PARENT/GUARDIAN'S NAME (PLEASE PRINT) SIGNATURE OF PARENT OR GUARDIAN

_____ _____

PARENT/GUARDIAN'S PHONE NUMBER DATE

PHYSICIAN'S ORDER FOR PRESCRIBED MEDICATION

Both state law O.R.C. and all Wapakoneta City Schools require the following information when children need administration of prescription drugs. Please complete the following information and forward to the school.

1. NAME OF STUDENT_____DOB_____
   LAST FIRST MIDDLE
2. ADDRESS _____
   STREET CITY/STATE/ZIP
3. SCHOOL_____ CLASS/GRADE_____
4. NAME OF MEDICATION_____
5. DOSAGE TO BE ADMINISTERED_____
6. TIMES AT WHICH THE MEDICATION IS TO BE ADMINISTERED_____
   _____
7. ADMINISTRATION OF MEDICATION TO BEGIN_____ END_____
   DATE DATE
8. SIGNIFICANT SIDE EFFECTS (ADVERSE REACTION) WHICH SHOULD BE REPORTED TO THE PHYSICIAN
   _____
   _____
9. SPECIAL INSTRUCTION FOR ADMINISTRATION OF THE DRUG, INCLUDING STERILE CONDITIONS AND STORAGE _____

_____ _____

PHYSICIAN'S SIGNATURE PHYSICIAN'S EMERGENCY PHONE NUMBER

THERE MUST BE NOTIFICATION TO THE SCHOOL IF ANY INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.