LICKING HEIGHTS LOCAL SCHOOLS

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Student_____ Grade_____

Address:_____

The above mentioned student is under my care for (diagnosis)_____

And should receive (Name of Drug, dosage, route)_____

_____

at the following time (s)_____

Administration to begin_____Administration to end_____

Specific Instructions for administration:_____

Possible side effects:_____

Name of Physician:_____

Address/Phone:_____

Signature of Physician:_____ Date:_____

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his delegate (school nurse or other responsible person) to administer the following medication to my child. I agree to deliver the medicine to the school in the container in which it was dispensed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

Name of Student:_____

Name of Drug: _____Dosage:_____Route:_____

at the following time(S)_____

Signature of Parent/Guardian_____Date:_____

Please fax back to Licking Heights Local Schools Clinic Attn: School Health Aide
Licking Heights West: Fax 614-501-4672; Phone 614-864-9089
Licking Heights South: Fax 740-964-1625; Phone 740-964-1674
Licking Heights North: Fax 740-927-5736; Phone 740-927-3268
Licking Heights Central: Fax 740-927-5845; Phone 740-927-3365
Licking Heights High School: Fax 740-927-3197; Phone 740-927-3197