Licking Heights Local Schools

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION OR TREATMENT BY SCHOOL PERSONNEL

Scheduling of medication or treatment outside of school hours is encouraged. When that is not possible, this form must be completed every school year prior to school personnel dispensing medication or treatment. This form is to be taken to the building principal and kept on file in the school office.

A. **To Be Completed By The Physician**
Student's Name___________________________________ Date of Birth______________
Prescribed Medication/Treatment____
Dosage, Time and Route____
Side Effects or Adverse Reactions to be reported to Parent or Physician______________
____
Instructions for Administration Including Storage and Sterile Requirements___________
____
Beginning Date__________________________ Ending Date________________________
Physician's Signature____
Physician's Address____
Physician's Phone Number____

B. **To Be Completed By The Parent/Guardian**
As parent/guardian of the above named child, my signature below authorizes the Principal, or other responsible school personnel to administer the medication or treatment to my child as instructed in Part A by the physician. I do assume responsibility for: 1. Safe Delivery of the medication in the original drugstore container to the school. 2. Providing the school with a new physician's request if the medication or the physician changes. 3. Instructing my child to present himself/herself and to take the medication at the prescribed time. 4. Understanding the medication will be disposed of the last day of school if not collected by the parent/guardian. 5. Holding the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature ___________________________________Date____________

Authorization For Staff

The following staff members are authorized to administer the above- prescribed medication(s) to the student:____
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