Form A

St. Joseph School
5411 South Main Street Sylvania, Ohio 43560

PARENTAL/PHYSICIAN
PERMISSION TO ADMINISTER MEDICATION

This form must be completed by the prescribing physician and parent prior to administration of medication by school personnel. All medication must be in the container in which it is dispensed by the prescribing physician or licensed pharmacist.

STUDENTS NAME: _____

ADDRESS: _____

SCHOOL: _____

PHYSICIAN'S STATEMENT: _____ is under my care
(Name)

and should receive _____
(Name of Drug and Dosage)

at the following time:_____

starting _____ ending _____
(Date) (Date)

Special Instructions for administration: _____

_____

Possible side effects to watch for: _____

_____

PHYSICIAN: _____ _____ _____
(Signature) **(Date)** **(Phone Number)**

PARENT STATEMENT: I hereby request and give my permission to the school nurse or the principal's designee to administer the medication as stated above by the physician. I agree to submit a revised statement signed by the physician if any of the information originally provided by the physician changes.

_____ _____
(Parent or Guardian Signature) (Date)

<u>New request forms must be submitted each School Year and whenever the Medication or Dosage is changed.</u>