

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

(Required in accordance with Ohio Revised Code 3313.713)

Date: _____

_____ (child's full name) residing at _____

_____, and a student in the

_____ grade at the _____ school in the Milford

Exempted Village School District, is under my care and must take medication which

I have prescribed during the school day.

Name of Medication (as it appears on container in which the drug is stored):..... _____

Dosage and time or intervals: _____

Date administration of drug is to begin: _____

Date after which the drug should not be administered: _____

Possible adverse reactions to be reported to physician: _____

Special instructions for the administration or storage of the drug: _____

Name of Physician:

(Print or Type)

(Primary Phone Number)

(Secondary Phone Number)

SIGNATURE OF PHYSICIAN