VALLEY MIDDLE SCHOOL

393 Indian Drive
Lucasville, Ohio 45648
Phone: (740) 259-2651
FAX: (740) 259-6624
www.valleyls.org

Aaron Franke
Principal
Jeff Rase
Guidance Counselor

Administering Prescription Drugs

PHYSICIAN'S STATEMENT

(As required by Ohio Law)

This form must have every item completed or the prescription will not be administered by school personnel.

TO BE COMPLETED BY YOUR PHYSICIAN

NAME OF STUDENT: _____

ADDRESS OF STUDENT: _____

SCHOOL: _____ GRADE: _____

NAME OF PRESCRIPTION: _____

DOSAGE OF PRESCRIPTION: _____

TIME OF DOSABE: _____

DATE DRUG IS TO BEGIN: _____ AND END: _____

ANY SEVERE REACTIONS THAT SHOULD BE REPORTED TO THE PHYSICIAN:

_____

_____

SPECIAL INSTRUCTIONS: _____

_____

If self-medication has been prescribed, please answer the following questions:

Has the student received instruction in self-administration of this medication? ___ Yes ___ No

Do you feel this student is qualified to self-administer this medication? ___ Yes ___ No

_____ _____ _____

Physician Signature Date Telephone Number

Important Information

The parent or guardian agrees to submit a revised statement signed by the physician if any of the information originally provided by the physician changes.

The drug is received by school authority in the container in which it was dispensed by the prescribing physician.

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give my permission for my child, _____, to be administered the above prescription drug as prescribed by his/her physician.

_____ _____ _____

Parent/Guardian Signature Address Date