

MIDVIEW LOCAL SCHOOLS  
AUTHORIZATION OF MEDICATION REQUEST

5330 F1

This form must be completed by both the physician who prescribes the medication and the parent or guardian prior to the school personnel being permitted to administer medication.

PHYSICIAN'S AUTHORIZATION (All items MUST be completed)

Student's Name: \_\_\_\_\_, Age \_\_\_\_\_ Physician's Name (print) \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Physician's Signature \_\_\_\_\_  
Parent/Guardian's Name \_\_\_\_\_ Emergency Telephone: ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_ Physician's Telephone: ( ) \_\_\_\_\_  
Parents/Guardian Telephone: ( ) \_\_\_\_\_  
Emergency Telephone: ( ) \_\_\_\_\_

This child is under my care for \_\_\_\_\_ and should receive  
(CONDITION)

\_\_\_\_\_ in the following dosage \_\_\_\_\_, at the following  
(EXACT NAME OF DRUG) (EXACT DOSAGE)  
time(s) \_\_\_\_\_ beginning on \_\_\_\_\_ and ending on \_\_\_\_\_.  
(EXACT HOURS) (DATE) (DATE)

This medication may cause the following adverse reaction which should be reported to the physician immediately: \_\_\_\_\_

This medication requires the following special storage or stile conditions (note: the school will provide storage for drugs needing refrigeration): \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION AND CONSENT

I, \_\_\_\_\_, \_\_\_\_\_, ( ) \_\_\_\_\_  
(Parent/ Guardian Name) (Address) (Phone No.)  
hereby request and give my consent to any employee of the School Board who has been duly authorized by the Board to administer to medication prescribed as directed by the physician or parent, for the following prescription drug: \_\_\_\_\_ to my child.

I also agree to comply with a the Ohio Law which requires me to deliver(highly preferred) or send the medication to the school in its original container and to comply with the guidelines of the School Board Policy which require me to receive the medication at is expiration dare or the end of the school wee, whichever occurs first and any other procedures which the Board may establish.

I also agree to submit to the school a revised statement signed by the physician named above if any of the information contained in the PHYSICIAN'S REQUEST changes.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)