Please Submit to Main Office When Needed

PHYSICIAN'S STATEMENT FOR ADMINISTERING PRESCRIPTION AND/OR NON-PRESCRIPTION DRUGS TO STUDENT
(In Compliance with ORC 3313.713)

Student's Name _____ Date of Birth _____

Address/City/State _____

Area Code and Phone No. _____

Vocational Program _____ 1st / 2nd Year (circle one)

(The following information is to be completed by physician.)

Name of drug to be administered _____

Dosage and times or intervals of drug to be administered _____

List any adverse reactions that should be reported to the physician and emergency phone number(s):

Reactions: _____

_____

Physician's Name _____ Phone No. _____

Special instructions for administration of drug, such as sterilization and storage:

_____

Physician's Signature _____ Date _____

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PARENT REQUEST FOR ADMINISTERING PRESCRIPTION OR NON-PRESCRIPTION DRUGS TO STUDENT
(To be Completed by the Parent/Guardian)

I grant permission for the administration of _____
(Name of medication)

be administered to my son/daughter _____ per the
(Student's Name)

instructions of our physician as shown above.

Parent/Guardian Signature _____ Date _____