Mapleton Local Schools

MEDICATION ADMINISTRATION REQUEST FORM

PRESCRIPTION MEDICATION, FOOD SUPPLEMENT, FLUORIDE, SUPPLEMENT, OR MODIFIED DIET

(O.R.C. 3313.713)

Student Name: ____ School: _______________ Grade: ______

Address: ____ Date of Birth: _________

____

TO BE COMPLETED BY LICENSED PRESCRIBER:

*One medication per form

Name of Medication ____

Reason for Medication ____

Dosage & Route of Medication ____

Time(s) each of is to be administered ____

Start Date _________________ Stop Date __________________

Special instructions, storage, or sterile conditions needed ____

Adverse reactions that need reported to prescriber ____

____

Signature of Licensed Prescriber Phone Date

____

Printed Name

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and given permission to the nurse or designee to administer the medication listed above to my child as instructed by physician and I agree to:

- Assume responsibility for safe delivery of the medication to school in its original container with the prescription label on the container.
- Immediately submit a revised form completed and signed by myself and the physician if there are any changes to the above medication or dosage.
- Grant permission for the nurse to confer with the above licensed prescriber regarding treatment issues pertaining to the above medication/diagnosis and educational/behavioral needs.
- Hold the board of Education, its officials, and its employees harmless from all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly for this authorization.

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Parent/Guardian Signature Date

____

Daytime Phone Number

Rev 8/21

This form expires at the end of the school year