

LISBON EXEMPTED VILLAGE BOARD OF EDUCATION

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STUDENT MEDICATION / PROCEDURE FORM

NAME: _____
ADDRESS: _____

TELEPHONE: _____
GRADE: _____
HOME ROOM: _____

NOTE: Sections I and II must be completed prior to the dispensing of any medication or medical procedures.

SECTION I. PARENT STATEMENT AND AUTHORIZATION

- 1 I understand that it is my responsibility to deliver any and all medication in the original prescription bottle to school personnel.
- 2 I understand that it is my responsibility to notify the school of any changes of the medication, dosage, or procedure.
- 3 I understand that it is my responsibility to provide any and all necessary refills of medications.
- 4 I authorize a designated employee of the school board to administer the prescribed medication as ordered for my child.
- 5 I authorize the school nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Signature of Parent/Guardian: _____ Date: _____

SECTION II. STATEMENT BY PHYSICIAN

- A. The above named student is under my care and I have prescribed the following medication/s for him/her:

Prescription	Dosage	When Administered
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- B. The student is being prescribed this medication for:

- C. Please indicate any possible reactions which should be reported to you.

- D. Please indicate any special instructions regarding the storage of this medication.

- E. Please indicate the expiration date of this request

Physician's Signature: _____

Physician's Name: _____

Physician's Telephone Number _____ Date: _____

The school nurse will be responsible for contacting the parent/guardian in regard to any medical questions which arise from school personnel, and will also be responsible for notifying the parent/guardian or physician of any adverse reactions.