

BUCKEYE LOCAL SCHOOLS

ADMINISTERING MEDICATION PRESCRIBED BY A PHYSICIAN

STATEMENT OF PHYSICIAN
FOR MEDICATION TO BE ADMINISTERED
BY SCHOOL EMPLOYEES

(R.C. 3313.713)

(NOTE: all blanks **MUST** be filled in)

Name of student _____

Address of student _____

School/class student is enrolled **BUCKEYE INTERMEDIATE SCHOOL**

Name of medication _____

Dosage to be administered _____

Time or intervals each dosage is to be
administered _____

Date the administration of
the medication is to begin _____

Date the administration of
the medication is to cease _____

Any severe adverse reactions
that should be reported to the
physician _____

One or more telephone numbers
at which the physician can be
reached in an emergency _____

Special instructions for
administration of the medication,
including sterile conditions and
storage _____

Name of physician _____

Address of physician _____

Date of this statement _____

Signature of physician _____

(over)

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I am the parent, guardian, or other person having care or charge of _____, who is a student assigned to **BUCKEYE INTERMEDIATE SCHOOL** and request that the medication described on the attached statement of the prescribing physician be administered to him/her.

I specifically agree that if any information on the attached Physician's Statement changes I will immediately submit to the school nurse or building principal a revised statement completed and signed by the prescribing physician.

Any school employee administering the medication described on the statement of the prescribing physician shall be entitled to rely upon the information contained therein until such time as a revised statement is submitted.

DATE _____

NAME OF PARENT _____

SIGNATURE OF PARENT _____

Any unused medication unclaimed by the parent will be destroyed by school personnel when a prescription is no longer to be administered or at the end of the school year.