FAIRPORT HARBOR SCHOOLS

Statement Of Prescriber
For Medication To Be Administered By School Employees
(O.R.C. 3313.713)

NOTE: **ALL** Blanks Must Be Filled In

Name of student: _____ Allergies: _____

School: (circle one) Elementary School ~ Middle School ~ High School

Grade level: _____ Teacher: _____ Age of student: _____

Name of medication: _____

Dosage to be administered: _____

Time or intervals at which 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 prescriber:

_____

One or more telephone numbers at which the prescriber can be reached in an Emergency: _____

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

Name of prescriber: _____

Address of prescriber: _____

Date of this statement: _____ Diagnosis: _____

Signature of prescriber: _____

Name of prescriber (print): _____

STATEMENT OF PARENT/GUARDIAN REQUESTING THAT SCHOOL EMPLOYEES ADMINISTER MEDICATION TO STUDENT
(O.R.C. 3313.713)

I, _____, am the parent, guardian or other person having care or charge of _____, who is a student at Fairport Elementary School ~ Middle School ~ High School (circle appropriate school).

I hereby request and give my consent that the medication described on the attached statement of the prescriber be administered to him/her by any employee of the Board of Education who has been duly authorized by the Board to administer medication to students.

I further agree that any school employee administering the medication described on the statement of the prescriber shall be entitled to rely upon the information therein contained until such time as a revised statement is submitted.

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

Date: _____

Signature of parent/guardian: _____

Name of parent/guardian: _____

Name of medication: _____

Daytime phone number: _____

NOTE

The reverse side of this form (Statement of Prescriber for Medication to be Administered by School Employees) must be completed by the student's prescriber.

FOR SCHOOL OFFICE USE ONLY

This medication request form has been properly completed by both the physician and the parent/guardian and the medication will be administered by authorized school employee(s).

_____

School Nurse