MARYSVILLE
Exempted Village School District
Innovate Collaborate Inspire

Board of Education
212 Chestnut St
Marysville, Oh 43040
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ADMINISTRATION OF MEDICATION REQUEST (Form MEVS H-2)

This form must be completed by both the physician who prescribes the medication AND the parent or guardian of the student prior to school personnel being permitted to administer medication.

PHYSICIAN'S REQUEST (all items MUST be completed)

_____
NAME OF STUDENT – Print **DOB**

_____
Complete Address **Parent/Guardian Phone**

is under my care for **(Condition)** _____

and should receive (**Exact Name and Strength of Drug**)_____

in the following dosage **(Exact amount)**_____and route_____

at the following time(s) **(Exact Hours)** _____

☐ For 2 hour delays, medications due between 7am and 10am may be given upon arrival to school per parent request.

Beginning on (DATE) _____ and Ending on (DATE) _____

This medication may cause the following adverse reactions which should be reported to the prescriber: _____

_____

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

_____

Physician's Name (Print) _____

Physician's Complete Address _____

Office Telephone _____ Alternate Emergency Phone No _____

Physician's Signature_____**Date**_____

PARENT OR GUARDIAN'S REQUEST

_____
NAME OF STUDENT – Print **Building/Class** **Grade**

I _____ parent/guardian of _____
Parent/Guardian – Print **Student's Name – Print**

hereby request and give my consent to any employee of the School Board who has been duly authorized by the Board to administer the medication prescribed as directed by the physician and parent/guardian for the following prescription drug

_____to my student.
Exact Name of Drug

I understand that a parent/guardian must personally deliver all prescription medication to the school office. I understand that pursuant to Ohio Revised Code Section 3313.713, medication must be in its original container in which it was dispensed by the prescriber or a licensed pharmacist, and I will submit to the building principal or designee assigned to my student's school building a revised authorization form if any of the above information changes.

Parent/Guardian's Signature _____**Date**_____

This medication request form has been properly completed by both the physician and the parent/guardian, and the school will administer the medication as outlined above.

Principal's or Designee's Signature _____**Date**_____