SIDNEY CITY SCHOOLS

750 S. FOURTH AVENUE
SIDNEY, OHIO 45365
MAIN: 937-497-2200
FAX: 937-497-2211

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Parent/Guardian's Name: _____ Phone: _____

Physician's Name: _____ Physician's Phone: _____

Physician's Fax Number: _____

PHYSICIAN - PLEASE COMPLETE:
The above-named student is under my care and should receive:
Name of Drug: _____ Dose: _____Times:_____

Reason for the drug to be administered at school: _____

Beginning date of request:_____ Expiration date of request:_____

Special instructions for administration: _____

Adverse reaction/Side effects to watch for: _____

Physician's Signature: _____ Date: _____

PARENT/GUARDIAN - PLEASE COMPLETE:
Parents MUST send medication to school in its original container.

Note: The parent/guardian of the child must assume responsibility for informing the principal or a designee (nurse, secretary, or other responsible trained person) of any change in the child's health or any change in the prescribed medication. Any change to the above prescription (dosage or administration) will require the completion of a new form.

PARENT'S PERMISSION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or a designee (nurse, secretary, teacher, or other responsible trained person) to administer the above medication to my child:

Parent/Guardian Signature _____ Date_____

School Official's Signature (Acknowledging Receipt): _____ Date _____

Office Use Only - Homeroom/Grade _____

Revised 11/24;6/25