Delphos City Schools

MEDICATION INFORMATION FORM
(FOR PRESCRIPTION & OTC MEDICINES)

PURPOSE: Many students are receiving medication under a doctor's supervision. It is important that the school be aware of the effects the medication might have or is having on the school performance of the students. School personnel are occasionally requested to administer the medication. Under these circumstances, it is necessary that specific physician's recommendations be made available to the school.

ALL STUDENTS taking medication are required to have this form on file in the school office to avoid misunderstanding.
IF MEDICATION IS PRESCRIBED BY A PHYSICIAN, THE PHYSICIAN MUST SIGN TO FORM.

NAME OF STUDENT: _____ DATE OF BIRTH: _____

BLDG. _____ GRADE: _____ TEACHER : _____

STUDENT ADDRESS: _____

MEDICATION IS TO START: _____ END DATE:_____

NAME OF MEDICATION: _____

REASON FOR MEDICATION: _____

RECOMMENDED DOSAGE/ROUTE: _____

TIMES ADMINISTERED: _____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OR STORAGE OF MEDICATION: _____

_____

OTHER MEDICATIONS STUDENT IS TAKING: _____

REACTIONS: The physician/pharmacist is urged to list potential reactions the student might have to this medication.
Physician/pharmacist's anticipated reaction to medication: _____

During school hours, it is my understanding that the school secretary, principal, or school nurse will administer the prescribed medication according to the specified physician's recommendation. In the case of school field trips, my child's teacher or trained staff member has my permission to administer the above medication. The school nurse may contact this physician at any time for information about my child's condition and/or medication orders. I agree to submit a revised statement signed by the prescriber if any of the information provided on this form changes. This form is valid for the current school year only and will serve as a Medical Release Form between school and healthcare provider.

(Physician signature is required for any prescription medication)

(Only the parent signature is required for OTC medicines)

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

Updated: 9/2026