

REQUEST FOR THE ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Xenia Community Schools
578 E. Market Street
Xenia, OH 45385

PART I - TO BE COMPLETED BY PHYSICIAN

[Please Print]

Name of Student		
Date of Birth		
School Building	Grade	
Name of medication to be administered or procedure required		
Quantity (dosage)	Times	Date to Begin
Possible reactions that might occur which should be reported to physician		
Special instructions, if required (administration of drug, sterile conditions, storage, etc.)		
Medication to be continued as above until (date)		
Physician's Name (please print)		
Physician's Address		
Physician's Phone No.	Physician's Emergency Phone No.	
Physician's Signature	Date	

PART II - TO BE COMPLETED BY PARENT OR GUARDIAN

WE (I) understand that the administration of said medication is to be done under the supervision of a member of the adult school staff.

FURTHER, we (I) understand that the school personnel are not legally obligated to administer oral medication to any child and, therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgement arising out of these arrangements which may be rendered against them.

FURTHER, we (I) agree to deliver the medication to the school in a container from the prescribing physician or licensed pharmacist, properly labeled by same, this label to include name of student, physician, date, dosage instructions (quantity and times). And name of medication.

FURTHER, we (I) will notify the school immediately if we change physicians or medication or terminate the use of this medication for any reason, and will report immediately to the school to pick up the remainder of said medication.

Signature of Father or Guardian		Date
Signature of Mother or Guardian		Date
Home Phone	Address	Work Phone

PART III - TO BE COMPLETED BY THE SCHOOL

Signature of Nurse	Date
Signature of Principal	Date

RETURN THIS FORM TO THE SCHOOL NURSE

Revised 9--04 / bg