

**PARENT'S REQUEST FOR THE ADMINISTRATION OF  
MEDICATION BY SCHOOL PERSONNEL**

I hereby authorize, request, and give my consent to the principal or his/her delegate (school nurse or other responsible person) to store, supervise, and/or administer the following medication to my child:

**Prescribed Medication** \_\_\_\_\_  
(Doctor's Written Note Attached)

**Non-Prescription Medication** \_\_\_\_\_

Name of Student: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Name of Medication, Dosage, and Route of Administration: \_\_\_\_\_

\_\_\_\_\_

Times of the Day to be Administered: \_\_\_\_\_

Date to Begin Medication: \_\_\_\_\_

Date to Complete Medication: \_\_\_\_\_

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during the school hours:       Yes       No

Please regard my signature below as my assurance that I release \_\_\_\_\_

\_\_\_\_\_ School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent or Guardian)

Fax Number: 330-342-4276

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

The following student is under my care and should receive the medication indicated below. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and therefore, must be taken during school hours.

Name of Student: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Name of Prescribed Medication and Dosage: \_\_\_\_\_

\_\_\_\_\_

Number of Times/Intervals Medication is to be Administered: \_\_\_\_\_

Dates Administration to Begin and End: \_\_\_\_\_

Adverse or Severe Reaction that Should be Reported to Physician: \_\_\_\_\_

\_\_\_\_\_

Special Instructions for Administration of Medication: \_\_\_\_\_

\_\_\_\_\_

This Medication Can Be Safety Administered by Non-Medical Personnel:  Yes  No

\_\_\_\_\_  
(Physician's Name)

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
(Date)

Amended S.B. 262  
Section 3313.713

One Medication per Card

Fax Number: 330-342-4276