Sandusky, Huron, Berlin-Milan, Kelleys Island, Margaretta,
Perkins, Vermilion, EHOVE, Erie County Special Education Classrooms.

Physician's Request for the Administration of Medication in School

Student's Name ______________________________ Date __________

Student's Address ______________________________ Phone __________

Building ______________________________ Grade or Class __________

Physician's order for medication in accord with 3313.713 Ohio Revised Code.

Medication	Route	Dose	Time of Administration

Starting date of this request __________ Termination date for medication __________

Special instructions (if any) ______________________________

Possible side effects * ______________________________

*** Each school building has been provided copies of AMA Patient Medication Instruction Sheets for the following (Circle, if appropriate):**

018 Belladonna Alkaloids and Barbiturates
009 Cephalosporins - Oral
031 Clindamycin/Lincomycin - Oral
016 Corticosteroids - Oral
034 Ergot Derivatives
010 Erythromycin
035 Indomethacin
015 Insulin
038 Iron Supplements
011 Nonsteroidal Anti-Inflammatory Drugs
007 Oral Antidiabetes Medicines
003 Penicillins - Oral
020 Sulfonamides
008 Tetracyclines
029 Thyroid Replacement
049 Acetaminophen
043 Antihistamines
047 Aspirin
044 Bronchodilator Aerosols
060 Steroid and Antibiotic Eye Drops

Drug should be administered by:

Student (Self) __________

School Personnel __________

____

____
Physician's Signature

____
Phone Number Where Physician Can Be Reached In Emergency

Additional forms are available to physicians from the Erie County Educational Service Center
2900 S. Columbus Ave., Sandusky, Ohio 44870

Parent's Request for the Administration of Medication in School

I request the school staff to administer the medicine to my child as ordered above by the attending physician. I will submit to the school a revised "Request" form signed by the physician and myself if there is any change in the above orders. I understand that I am required by Ohio law to provide the school with the medication in the original container as dispensed by the physician or pharmacist.

Date __________ Parent's Signature ______________________________

Reminder:
Medication must be provided to school in original container dispensed by the physician or pharmacist.

____
Parent's Address

____
Home Phone

____
Work Phone