

REQUEST FOR STUDENT'S MEDICATION IN SCHOOL

(in accordance with 3313.716 Ohio Revised Code)

SCHOOLS: Berlin-Milan, EHOVE, Erie County Special Education Classes, Huron, Margaretta, Perkins, Vermilion

FAX: Woodlands (419) 433-9619

McCormick 433-8427

Huron High School 433-2339

PHYSICIAN

Student's Name _____ D.O.B. _____

Medication _____

Dosage & Time _____

Starting Date _____ Termination Date _____

Special Instructions _____

Any adverse reaction that should be reported to Physician _____

IF PRESCRIBING AN ASTHMA INHALER:

Authorization to carry the Inhaler ____ Yes ____ No

Any adverse reactions to student or unauthorized user that should be reported to the physician: _____

Procedure to follow in the event that inhaler does not produce relief from asthma attack: _____

Physician's Printed Name _____ Phone _____

Physician's Signature _____ Date _____

PARENT

I request that medication be administered as instructed by my child's physician / dentist. I understand that:

A new form must be submitted each school year and whenever the medication or dosage is changed.

I am required by Ohio law to provide the school with the medication in the original container as dispensed by the pharmacist.

Parent's Signature _____

Date _____

Parent Emergency Daytime Phone _____

(N4:MEDS.SCHOOL)