

OTSEGO LOCAL SCHOOLS  
**REQUEST FOR ADMINISTRATION OF MEDICATION  
BY SCHOOL PERSONNEL**

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Social Security #

**IMPORTANT INFORMATION:**

1. **All medication should be received in the container in which it was dispensed--whether prescription or non-prescription.**
2. **Medication will not be administered if any of requested information is omitted or unclear to person(s) authorized to administer medication.**

**INSTRUCTIONS:**

- A. To be completed by parent/guardian if request is for non-prescription drugs.
- B. To be completed by physician if medication has been prescribed by physician.

1. Name of Student \_\_\_\_\_

2. Address/Town of Student \_\_\_\_\_

3. Name of Drug \_\_\_\_\_

4. Dosage of drug to be administered and method \_\_\_\_\_

5. Date administration is to begin \_\_\_\_\_

6. Date administration is to cease \_\_\_\_\_

7. Please report any adverse reaction that might be expected: \_\_\_\_\_

8. Please provide any special instructions including sterile conditions/storage: \_\_\_\_\_

9. INHALERS carried by students: Ohio Law requires physician to supply information regarding adverse reaction if used by another child. Adverse reactions would include: \_\_\_\_\_

**IF PRESCRIBED BY PHYSICIAN:**

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Telephone Number/Office

\_\_\_\_\_  
Emergency Number

It is the obligation of the parent, guardian or person having care of the child to provide a written, revised statement signed by a physician (if prescription medicine) if the information given above should change.

I have read and understand the condition of this request and verify that the above information has been accurately provided. I hereby give permission for the school designated to administer medication to my child.

\_\_\_\_\_  
Parent's Signature \_\_\_\_\_

Building \_\_\_\_\_

Grade \_\_\_\_\_

Teacher's Name \_\_\_\_\_