# Marysville Exempted Village Schools

1000 Edgewood Drive, Marysville, Ohio 43040
Board of Education (937) 578-6100 Fax (937) 578-6113


## ADMINISTRATION OF MEDICATION REQUEST

(Form MEVS H-2)

**This form must be completed by both the physician who prescribes the medication and the parent or guardian of the student prior to school personnel being permitted to administer medication.**

PHYSICIAN'S REQUEST (all items MUST be completed)

_____ Age _____ Building _____ Grade Level _____
**(NAME OF STUDENT) – PRINT**

_____ ( ) _____
(Parent/Guardian) - Print (Complete Address) Phone

is under my care for _____ and should receive _____
(Condition) (Exact Name of Drug)

in the following dosage _____ at the following time(s) _____
(Exact Amount) (Exact Hours)

Beginning on _____ and ending on _____
(Date) (Date)

This medication may cause the following adverse reactions which should be reported to the undersigned immediately

_____

This medication requires the following special storage or sterile conditions (note: the school will provide storage for drugs needing refrigeration

_____

Physician's Name (Print) _____

Physician's Address _____
Number Street City State Zip

Office Telephone ( ) _____ Alternate Emergency Phone No ( ) _____

_____ _____
**(Physician's Signature)** **(Date)**

PARENT OR GUARDIAN'S REQUEST

I _____, _____ ( ) _____
(Parent/Guardian)- Print (Address and Phone)

Hereby request and give my consent to any employee of the School Board who has been duly authorized by the Board to administer the medication prescribed as directed by the physician or parent, for the following prescription drug _____ to my child.
(Exact Name of Drug)

I also agree to comply with the Ohio law which requires me to deliver the medication to the school in its original container and to comply with the guidelines of school Board policy which requires me to receive the medication at its expiration date or the end of the school year, whichever occurs first and any other procedures which the Board may establish.

I also agree to submit to the school a revised statement signed by the physician named above if any of the information contained in the PHYSICIAN'S REQUEST changes.

_____ Date: _____
(Parent/Guardian's Signature)

This medication request form has been properly completed by both the physician and the parent/guardian, and the school will administer the medication as outlined.

Principal's or Designee's Signature _____ Date _____

*Our Mission: To effectively and efficiently provide learning opportunities that challenge all students to realize their maximum potential.*