Springboro Community City School District
1685 South Main Street
Springboro, OH 45066
(937) 748-3960

REQUEST TO ADMINISTER **PRESCRIPTION MEDICATION** OR OTHER MEDICAL PROCEDURES

To be completed by the physician

Student Name ____ Today's Date ________________________

Student Address ____ Telephone ________________________

School ________________________________ Grade ________________________

Medication, dosage, and times to be administered:

____

Possible reactions that should be reported to the physician:

____

Special instructions, including storage and sterile requirements:

____

Date when medication or procedures is no longer needed:

____

____
(Physician's Signature) (Physician's Telephone)

____
(Physician's Address) (Date)

To be completed by the parent:

I, hereby, authorize designated personnel of the Springboro Community City School District to administer the above named medication or procedure as instructed by the physician, and agree to:

1. Provide the school with the medication in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
2. Notify the school if we change physicians.
3. Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.
4. Release authorized school employees from all liability, cause of action, or any other responsibility for administering said medicines as noted above.

____
(Parent / Guardian Signature) (Parent / Guardian Telephone)

____
(Parent / Guardian Address) (Date)

To be completed by school personnel:

I, hereby, acknowledge reading this request to administer medication; and understand its content, as well as the content of the Board policy printed on the back of this form.

____
(School Nurse's Signature) (Date)

Revised 11/2014