NORTHWEST LOCAL SCHOOL DISTRICT

800 Mohawk Drive
McDermott, OH. 45652

NES: 740-259-2250
Nurse ext. 3306/Fax: 740-259-8542

NMS: 740-259-2528
Nurse ext. 2102/Fax: 740-259-5731

NHS: 740-259-2366
Nurse ext. 1348/Fax: 740-259-8544

Administering Prescription Medication
Physician Statement
(As required by Ohio Law)

To Be Completed By Your Physician

Name of Student _____ Birthdate _____
Address of Student _____
School _____ Grade _____
Name of Prescription Medication _____
Dosage of Prescription Medication _____
Time of Medication _____
Date Prescription Medication is to Begin _____ And End _____
Any severe reactions that should be reported to the physician _____
_____
Reason for Medication _____
_____
Special Instructions _____
_____

If self-administered medication is prescribed, please complete the following questions:

1. Has the student received instruction on self-administration of medication?_____ Yes ____ No
2. Do you think this child is qualified to self-administer this medication? (this ONLY applies to the use of inhalers, Epi-pens, insulin and glucose administration)?____ Yes ____ No

_____ _____ _____
(Physician's Signature) (Telephone Number) (Date)

Important Information:
The parent or guardian agrees to submit a revised statement signed by the physician if any of the information originally provided by the physician changes.
The medication must be received by school authority in the container in which it was dispensed by the pharmacy.

******MEDICATION MUST BE BROUGHT TO THE SCHOOL BY THE PARENT OR GUARDIAN******

To Be Completed BY The Parent or Guardian

I hereby give permission for _____ to be administered the above prescription medication as prescribed by his/her physician.

_____ _____
(Parent or Guardian Signature) (Address)

_____ _____
(Telephone Number) (Date)