

**NORTHWEST LOCAL SCHOOL DISTRICT**

**800 Mohawk Drive  
McDermott, OH. 45652**

**NES: 740-259-2250**

**NMS: 740-259-2528**

**NHS: 740-259-2366**

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

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

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)