Request for Administering Medication

Valley View Local Schools

59 Peffley St.

Germantown, OH 45327

Name of Student: _____

Address of Student: _____

Home Phone Number: _____ Cell Phone: _____ Work Phone: _____

School (please circle) Preschool Primary Intermediate Jr. High High School Grade: _____

Name of Medicine: _____ Dosage: _____

Administration Begin Date: _____ Stop Date: _____

Special Instructions for Administration and/or Storage: _____

_____

_____

Possible Severe Adverse Reactions that should be Reported to Physicians: _____

_____

_____

Name of Physician: _____

Address of Physician: _____

Office Phone Number: _____ Office Fax Number: _____

Signature of Physician: _____

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I request that the above described medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the original container in which it was dispensed by the prescribing Physician or Licensed pharmacist. If the information changes, I will submit a new Request for Medication Administration form signed by the Physician.

Parent/Guardian: _____ Date: _____