Walnut Township Local School District P.O. Box 278, Millersport, Ohio 43046 (Phone 740 467-2261 - Fax 740 467-3494)

Dispensing of Prescription Medication

Parental Request

Student's Name_____ Class/Grade_____

Address_____

I hereby request and give my permission to the school principal or designee (school nurse or other responsible person) to administer medication/procedure, as prescribed by the physician, to my child. I, the undersigned, release school personnel from liability in dispensing any medication or performing any procedure authorized by me. In addition, I understand that it is my responsibility to see that the medication needed and equipment needed is delivered to the school and to notify the school as to any changes in medication, procedure and/or physician.

(ALL MEDICATION MUST BE LEFT IN ITS ORIGINAL CONTAINER).

Parent's Signature_____ Date_____

Telephone Number_____

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Physician's Statement

The following prescription drug is to be administered to the above named student:

Name of drug_____ Dosage_____

Dates to be administered_____ Through_____

Time of day to be administered_____

Special instructions for administration of the drug_____

Please report the following severe reactions_____

A revised statement, signed by the physician, must be submitted to the school if there is a change in the info. provided above.

Physician's Signature_____ Office Address_____

Telephone_____

Dispensing of Non-Prescription Medication

Student's Name_____ Grade/Class_____

Brief description of student's condition_____

Type of medication_____ When to be administered_____

Physician authorizing use of medication_____

Other remarks_____

I am requesting that school personnel administer medication to my child as described above. It is understood that teachers, nurse, administrators or secretaries assume no liability in the dispensing of medication to my child.

*******ALL MEDICATION MUST BE LEFT IN ITS ORIGINAL CONTAINER*******

Parent's Signature_____ Date_____