

**Champion Local Schools**

**5759 Mahoning Ave N.W.**

**Warren, Ohio 44483**

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY  
SCHOOL PERSONNEL

\_\_\_\_\_  
**Name of Student**                      **Address**                      **School Bldg.**  
**Grade**

Is under my care and should receive \_\_\_\_\_  
**Name of Drug, Dosage, and Route**

At the following times \_\_\_\_\_

Specific Instructions for Administration: \_\_\_\_\_

Possible Side Effects to Watch for: \_\_\_\_\_

Possible Reactions to be Reported to Physician: \_\_\_\_\_

Special Instructions Including Storage and Sterile Requirements: \_\_\_\_\_

\_\_\_\_\_  
Expiration Date of This Request: \_\_\_\_\_

\_\_\_\_\_  
**Date**                      **Physician's Signature**                      **Physician's Phone**  
**#**

I, \_\_\_\_\_, Parent/Guardian \_\_\_\_\_  
**Name of Parent/Guardian**                      **Name of Student**

Authorize the principal or designee (school nurse or other responsible person) to administer the medication or procedure as instructed by the physician and agreeing:

1. To send all medication in a **labeled prescription bottle or envelope**. (This gives us the doctor's authorization to dispense medication. We cannot accept medication in a plastic baggie or envelope not labeled from the doctor's office or pharmacy.)
2. To notify the school if there is a change in physician.
3. Notify the school if the medication, dosage, or procedure is changed, or to be eliminated.
4. My child has been instructed in the proper use of the asthma inhaler and will notify the teacher every time it is used.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/Guardian**