WEST BRANCH LOCAL SCHOOL DISTRICT
MEDICATION ADMINISTRATION PERMIT
(In accordance with Ohio Revised Code 3313.713)

STUDENT NAME______________________________ SCHOOL________________
STUDENT BIRTHDATE_______________________ GRADE_______
STUDENT ADDRESS____
PARENT(S) NAME_____________________________ PHONE________________
EMERGENCY CONTACT NAME________________________________
EMERGENCY CONTACT PHONE________________________________
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THIS SECTION TO BE COMPLETED BY THE PHYSICIAN

*MEDICATION TO BE ADMINISTERED*___________________________________
*DOSAGE TO BE ADMINISTERED*______________________________________
*ROUTE OF ADMINISTRATION*____
*TIME(S) MEDICATION IS TO BE GIVEN*_________________________________
ADVERSE REACTIONS TO BE REPORTED ______________________________
____
*SPECIAL INSTRUCTIONS*____
____

DATE TO BEGIN_________________ DATE TO END_________________
DATE OF AUTHORIZATION____________________________

Prescribing Physician (print)____________________ Signature ____________________
Physician's address____
Physician's emergency phone_________________ Alternate phone_______________
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THIS SECTION TO BE COMPLETED BY THE PARENT(S)

I request the school personnel to administer the medication as instructed and agree to (1) deliver the medication to the school in the **original container** (2) notify the school if I change physicians (3) notifiy the school if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I agree to hold school employees and the Board of Education free from all responsibility for results of such medication.

PARENT(S) SIGNATURE_______________________ DATE_______________
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FOR SCHOOL USE ONLY

The following school personnel have read this form and are authorized to administer the medication as outlined:

Signature______________________________ Date_____________
Signature______________________________ Date_____________
Signature______________________________ Date_____________
Signature______________________________ Date_____________