MADISON-PLAINS LOCAL SCHOOLS
PHYSICIAN'S REQUEST FORM FOR ADMINISTERING MEDICATION TO STUDENT

Name of Student:____
Grade: __________________ DOB: _______________ Date: ________________
Name of Parent/Guardian:____
Street Address or PO Box:____
City:_________________________ State: _________ Zip Code: _________________
Home Telephone:____________________ Mobile Telephone:________________________
Name of Physician:____
Address: ____ Phone:________________

I authorize the school personnel to administer medication or procedure as instructed by the physician and agree:

1. To deliver the medication to the school
2. To notify the school if physician is changed.
3. To notify the school if medication, the dosage or procedure is changed or to be eliminated.

Medication and dosage or procedure required:______________________________________
____
____

Times required: _________________________________

Possible reactions which should be reported to the physician:____________________________
____
____

Special instructions (storage & sterile requirements):_________________________________
____
____

Date medication or procedure no longer needed: ____________________________________

PHYSICIAN'S
SIGNATURE: __________________________ DATE: ______________

Signature or Parent/Guardian: ____

Date of request: ____

Signature of Principal: ____

Signature(s) of person(s) authorized to administer medication:

____

Please submit form to the Madison-Plains School Nurse by fax at 740-490-0612 or mail to:
Madison-Plains Intermediate School
9940 St. Rt. 38 SW
London, Ohio 43140
740-490-0610