Licensed Prescriber's Statement for

Prescription Medication Administration

Parkway Local Schools

To the physician:

Parkway Local Schools requires that all of the following information be provided before it will administer medication or treatment to the student. **Parent/guardian must bring the medications to school. Medications are not allowed on school busses according to Ohio Revised Code.**

Student Name: _____ School: Parkway Local Schools
Grade: _____

I am a licensed health care professional authorized to prescribe medications, and I have prescribed the following medications to the above named student:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Date administration is to begin: _____, 20_____
Date administration is to cease: _____, 20_____

Specify any additional instructions for administration, including sterile conditions and storage: _____
_____

As the physician, I ask the following side effects be report to my office immediately:
_____
_____
_____
_____
_____

Physician's Signature: _____ Telephone: _____

Printed/Typed Name: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Telephone:_____ Cell:_____