MILFORD EXEMPTED VILLAGE SCHOOLS
PROVIDER'S OR LICENSED INDIVIDUAL REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL
(Required in accordance with Ohio Revised Code 3313.713)

It is necessary that _____ (student's full name) residing at _____, and a student in the _____ grade at _____ School must take medication, which I have prescribed, during the school day.

Medication *(Name as it appears on container)*	Dosage	Time(s)	Duration
_____	_____	_____	_____
_____	_____	_____	_____

Possible reactions to be reported to the physician:

_____

_____

Special instructions for medication administration:

_____

_____/_____/_____
Provider's Signature Print Name Phone Number

_____ _____
Address Date

****

I/We the parent(s) of _____ assume responsibility for the safe delivery of my son's/daughter's medication and the signed permission forms to school. I/We will notify the school if the medication, dosage, or physician is changed.

_____ _____ _____
Parent's Signature Phone Date

NO PRESCRIPTION MEDICATION WILL BE GIVEN WITHOUT A PRESCRIBER'S ORDER.