Request for Administration of Medication at School

Xenia Community Schools

▪Arrowood Elementary 1588 Pawnee Dr. Xenia, OH 45385 Fax: 937-374-4402 Ph: 937-372-9251	▪Cox Elementary 506 Dayton Ave Xenia, OH 45385 Fax: 937-374-4723 Ph: 937-372-9201	▪McKinley Elementary 829 Colorado Dr. Xenia, OH 45385 Fax: 937-374-4406 Ph: 937-372-1251	▪Shawnee Elementary 92 E. Ankeney Mill Rd Xenia, OH 45385 Fax: 937-374-4230 Ph: 937-372-6461	▪Tecumseh Elementary 1058 Old Springfield Rd Xenia, OH 45385 Fax: 937-374-4398 Ph: 937-372-3321	▪Warner Middle School 600 Buckskin Trail Xenia, OH 45385 Fax: 937-562-9962 Ph: 937-376-9488	▪Xenia High School 303 Kinsey Rd Xenia, OH 45385 Fax:937-352-4450 Ph: 937-372-6983	▪Xenia Preschool 425 Edison Blvd. Xenia, OH 45385 Fax:937-374-4218 Ph: 937-562-9706

PART I- TO BE COMPLETED BY PHYSICIAN

Student Name:	Date of Birth:
School Building:	Grade:
Medication to be administered or procedure required:	
Quantity (dosage):	Times:
Date to begin:	Date to discontinue:
Special instructions or possible reactions that should be reported to physician:	
Physician Name:	Physician Phone:
Physician Address:	
Physician Signature:	Date:

PART II- TO BE COMPLETED BY PARENT OR GUARDIAN

We (I) understand that the administration of said medication is to be done under the supervision of a member of the adult school staff.

Further, we (I) understand that the school personnel are not legally obligated to administer oral medication to any child and, therefore, we (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgement arising out of these arrangements which may be rendered against them.

Further, we (I) agree to deliver the medication to the school in a container from the prescribing physician or licensed pharmacist, properly labeled by same, this label to include name of student, physician, medication, date, and dosage instructions (quantity and times).

Further, we (I) will notify the school immediately if we change physicians or medication or terminate the use of this medication for any reason, and will report immediately to the school to pick up the remainder of said medication.

Parent/Guardian Signature:		Date:
Address:		
Home Phone:	Cell Phone:	Work Phone:

PART III- TO BE COMPLETED BY SCHOOL

Nurse Signature:	Date:
Principal Signature:	Date:

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

Revised 3/18