DELPHOS CITY SCHOOLS

MEDICATION INFORMATION FORM

PURPOSE: Many students are receiving medication under a doctor's supervision. It is important that the school be aware of the effects the medication might have or is having on the school performance of the students. School personnel are occasionally requested to administer the medication. Under these circumstances, it is necessary that specific physician's recommendations be made available to the school.

ALL STUDENTS taking medication are required to have this form on file in the school office to avoid misunderstanding. **IF MEDICATION IS PRESCRIBED, PHYSICIAN MUST SIGN FORM.** Over the counter medications will require the signature of the parent only. Medications must be brought to school in the original containers.

STUDENT NAME: ______________________________ BLDG: ____________________

GRADE: __________ TEACHER: ____________________________________

STUDENT ADDRESS: ____

MEDICATION IS TO START: ____________________ END DATE: ________________

NAME OF MEDICATION: ____

RECOMMENDED DOSAGE/ROUTE: ____________________________________

TIME(S) ADMINISTERED: ____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OR STORAGE OF MEDICATION:

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OTHER MEDICATIONS STUDENT IS TAKING: ______________________________

REACTIONS: The physician/pharmacologist is urged to list potential reactions the student might have to the medication.

Physician/Pharmacologist anticipated reactions to medication: ____________________________

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During school hours, it is my understanding that the school secretary, principal, or school nurse will administer the prescribed medication according to the specified physician's recommendation. In the case of school field trips, my child's teacher has my permission to administer the above medication. The school nurse may contact this physician at any time for information about my child's condition. I agree to submit a revised statement signed by the prescriber if any of the information provided on this form changes. This form is valid for the current school year only and will serve as a Medical Release Form between school and healthcare provider.

Parent Signature: ______________________ Phone: ______________ Date: __________

Physician Signature: ______________________ Phone: ______________ Date: __________