



MEDINA CITY SCHOOLS
Medina High School

ADMINISTERING MEDICATION
Prescribed by a Physician

STATEMENT OF PHYSICIAN
FOR MEDICATION TO BE ADMINISTERED BY SCHOOL EMPLOYEES
(R.C. 3313.713)

[Note: all blanks must be filled in]

Name of student _____

Address of student _____

School and class in
which the student is enrolled _____

Name of the medication _____

Dosage to be administered _____

Time or intervals at which
each dosage is to be administered _____

Date the administration of
the medication is to begin _____

Date the administration of
the medication is to cease _____

Any severe adverse reactions
that should be reported to the
physician _____

One or more telephone numbers
at which the physician can be
reached in an emergency _____

Special instructions for
administration of the medication,
including sterile conditions and
storage _____

Name of physician _____

Address of physician _____

Date of this statement _____

Signature of physician _____



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Medina High School

ADMINISTERING MEDICATION
Prescribed by a Physician

STATEMENT OF PARENT OR GUARDIAN
FOR SCHOOL EMPLOYEES TO ADMINISTER
MEDICATION PRESCRIBED BY A PHYSICIAN TO STUDENTS
(R.C. 3313.713)

I am the parent, guardian, or other person having care or charge of

_____, who is a student assigned to
_____ and request that the medication
described on the attached statement of the prescribing physician be administered to him/her.

I specifically agree that if any information on the attached Physician's Statement changes I will immediately submit to the school nurse or building principal a revised statement completed and signed by the prescribing physician. Any school employee administering the medication described on the statement of the prescribing physician shall be entitled to rely upon the information therein contained until such time as a revised statement is submitted.

Date _____

Signature _____

Name of parent _____