INDIAN VALLEY LOCAL SCHOOLS
REQUEST FORM FOR ADMINISTRATION OF:
PRESCRIPTION/NON-PRESCRIPTION MEDICATION
ASTHMA INHALER or EMERGENCY MEDICATION (Epi-Pen)

TO BE COMPLETED BY THE PHYSICIAN

Since medication for the student listed below cannot be scheduled for any time other than during school hours and the administration of prescription/non-prescription medications, asthma inhaler or emergency medications may be supervised by non-medical personnel, it is requested that the medication as indicated below be administered by the school nurse or a school designee. Medication order is valid for one school year.

PHYSICIAN'S STATEMENT

(Please print or type)

Date_____Grade_____School Building_____
Name of Student_____Date of Birth_____
Address_____
Parent/Guardian _____
Phone (Home#)_____(Work#)_____(Cell#)_____
Medication Name:_____
Dosage:_____
Route of Administration:_____
Time or intervals dosage of drug is to be administered:_____
Date the administration is to begin:_____
Date the administration is to cease:_____
Adverse reactions that should be reported to the prescriber:_____
_____
Special instructions, if any, for administration or storage of the drug:
_____
If an inhaler or emergency medication is given, what procedure is to be followed in the event that medication does not produce the expected relief from the student's asthma attack or other condition requiring emergency medication:
_____

SIGNATURE OF THE PHYSICIAN_____Date_____
ADDRESS OF THE PHYSICIAN_____
One or more phone numbers where the physician can be reached in an emergency_____

PARENT'S STATEMENT

I will assume responsibility for the safe and timely delivery of medication to the school.
I will notify the school immediately if there is any change or discontinuance in the use of the medication or the prescribed treatment.
I give my permission for the school nurse to call the prescriber if there are any questions or clarifications needed.
I will release and agree to hold the Board of Education, its officials, and its employees harmless from any foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

SIGNATURE OF THE PARENT/GUARDIAN **DATE**

Building	**Phone Number**	**Fax Number**
Midvale Elementary	330-339-1191	330-339-1194
Port Washington Elementary	740-498-8389	740-498-6312
Middle School	740-922-4226	740-922-2493
High School	740-254-4262	740-254-4911

INDIAN VALLEY LOCAL SCHOOLS MEDICATION RECEIPT

DATE_____

BUILDING:

HIGH SCHOOL_____

MIDVALE ELEMENTARY_____

PORT WASHINGTON ELEMENTARY_____

TUSCARAWAS MIDDLE SCHOOL_____

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STUDENT'S NAME_____

GRADE/TEACHER_____

MEDICATION NAME & DOSAGE_____

AMOUNT OF MEDICATION
RCVD/RETURNED_____

STAFF SIGNATURE RECEIVING MEDICATION_____

PARENT/GUARDIAN SIGNATURE_____

COMMENTS/CONCERNS/FURTHER
INSTRUCTIONS_____

_____

_____

_____

_____

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