A ministry of the Church of the Nazarene 650 Walhonding Ave., Logan, Ohio 43138
www.loganchristianschool.com Fax and Phone: 740-385-5360

ADMINISTRATION OF PRESCRIPTION MEDICATION- PHYSICIAN & PARENT REQUEST FORM

Student Name: ____ DOB: ______________

TO THE PHYSICIAN: Please complete all areas of this form. All information requested is required by Ohio Law. Thank you very much.

Name of Medication: ________________________________ Dosage: ____________________

Times to be administered: ____

Method of administration: ____

Date to begin medication: _________________ Date to end medication: __________________

Possible side effects or adverse reactions to watch for: __________________________________

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Special instructions regarding the administration or storage of medication: _________________

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Physician Signature: ____ Date: ___________

Physician Phone Number: _______________________________________

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I give my permission for the above named medication to be administered to my son/daughter by LCS staff during school hours in my absence.

Parent Signature: ____ Date: __________

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This form must be completed in its entirety. All medication must be sent in the original container in which it was purchased. Pleas seal the medication in a “Ziploc” type bag or large envelope and bring to the SCHOOL OFFICE. All medication will be given to the student in the presence of Board-designated personnel. All administrations will be recorded on the Medication Administration Form on the back of this page at the times that they occur.