IRONTON CITY SCHOOLS

"TO TEACH, TO NURTURE, TO SERVE"

Physician Request for the Administration of Medication by School Personnel

Physician: _____

FAX: _____

☐ Ironton Elementary School (740)532-3077 (Fax)

☐ Ironton Middle School (740)532-3077 (Fax)

☐ Ironton High School (740)533-6027 (Fax)

_____ is under my care for _____
Student's Name Diagnosis

and should receive _____
Name of Medication Dosage and route at the following times

Specific instructions for administration _____

Possible side effects _____

Expiration date of this request: _____

Physician Name:_____ Phone Number: (_____)_____
(Please Print)

Physician's Address: _____

Physician Signature: _____Date: _____

Parent's Request for the Administration of Medication by School Personnel

I hereby request and give permission to the principal or his/her designee to administer the following medication to my child and permission to share any medical information with the physician on their behalf.

Name of child _____Name of Medication_____

Dosage _____ Route _____ Times_____

Parent Signature _____ Date: _____

Nurse Signature _____ Date: _____

Principal Signature _____ Date: _____

CaseNotes:

_____

_____

_____