MARYSVILLE
Exempted Village School District
Innovate Collaborate Inspire

Board of Education
1000 Edgewood Dr.
Marysville, OH 43040
Office 937-578-6100
Fax 937-578-6113
www.marysville.k12.oh.us

ADMINISTRATION OF MEDICATION REQUEST (Form MEVS H-2)

This form must be completed by both the physician who prescribes the medication and the parent or guardian of the student prior to school personnel being permitted to administer medication.

PHYSICIAN'S REQUEST (all items MUST be completed)

_____
NAME OF STUDENT – Print DOB

_____
Complete Address Phone

is under my care for **(Condition)** _____

and should receive **(Exact Name of Drug)** _____

in the following dosage **(Exact Amount)** _____

at the following time(s) **(Exact Hours)** _____

Beginning on (date) _____ and ending on (date) _____

This medication may cause the following adverse reactions which should be reported to the undersigned immediately

_____

This medication requires the following special storage or sterile conditions (note: the school will provide storage for drugs needing refrigeration)

_____

Physician's Name (Print) _____

Physician's Complete Address _____

Office Telephone _____ Alternate Emergency Phone No _____

_____
Physician's Signature **Date**

PARENT OR GUARDIAN'S REQUEST

_____
NAME OF STUDENT – Print Building Grade

I_____, parent/guardian of _____
Parent/Guardian – Print Student's Name – Print

Hereby request and give my consent to any employee of the School Board who has been duly authorized by the Board to administer the medication prescribed as directed by the physician or parent, for the following prescription drug

_____to my child.
Exact Name of Drug

I also agree to comply with the Ohio law which requires me to deliver the medication to the school in its original container and to comply with the guidelines of school Board policy which requires me to receive the medication at its expiration date or the end of the school year, whichever occurs first and any other procedures which the Board may establish.
I also agree to submit to the school a revised statement signed by the physician named above if any of the information contained in the PHYSICIAN'S REQUEST changes.

_____Date_____
Parent/Guardian's Signature

This medication request form has been properly completed by both the physician and the parent/guardian, and the school will administer the medication as outlined.

Principal's or Designee's Signature _____Date_____