



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.

Board of Education

1000 Edgewood Dr.
Marysville, OH 43040
Office 937-578-6100
Fax 937-578-6113

Early College High School

833 N Maple St
937-578-7300
FAX 937-578-7313

Marysville High School

800 Amrine Mill Rd
937-578-6200
FAX 937-578-6213

Bunsold Middle School

14198 SR 4
937-578-6400
FAX 937-578-6413

Creekview Intermediate

2000 Creekview Dr
937-578-6600
FAX 937-578-6613

Edgewood Elementary

203 Grove St
937-578-6800
FAX 937-578-6813

Mill Valley Elementary

633 Mill Wood Blvd
937-578-6900
FAX 937-578-6913

Navin Elementary

16265 County Home Rd
937-578-7000
FAX 937-578-7013

Northwood Elementary

2100 Creekview Dr
937-578-7100
FAX 937-578-7113

Raymond Elementary

21511 Main St
Raymond, OH 43067
937-578-7200
FAX 937-578-7213

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

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.

Parent/Guardian's Signature Date

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 _____