DISCOVERY SCHOOL
www.discovery-school.net
855 Millsboro Road
Mansfield, Ohio 44903
(419) 756-8880

Dispensing **Prescription Medicine** at Discovery School
(This form is required for each school year.)

REQUEST FOR THE ADMINISTRATION OF

PRESCRIPTION MEDICATION

BY AUTHORIZED DISCOVERY SCHOOL PERSONNEL FOR THE SCHOOL YEAR ____________________

SECTION I: PARENT REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

I hereby request and give permission to the authorized personnel to administer the following medication to my child:

Name of Child | Age of Child | Name of Medication To Be Administered

Dosage | Time(s) of Dosage | Signature of Parent | Date

SECTION II: PHYSICIAN'S OR DENTIST'S INSTRUCTIONS

________________________ is under my care and should receive ________________________
(Name of Child) (Name of Medication)

as follows: ________________________
(Dosage)

Specific instruction for administration: ________________________

Possible side effects: ________________________

Expiration date (may not exceed six months from date of this request):

Signature of Physician or Dentist | Date | Phone Number

Please print physician's/dentist's name

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DIVISION OF EDUCATIONAL SERVICES

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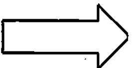

Name of Student

SECTION II: (cont.) MEDICATION GIVEN BY AUTHORIZED DISCOVERY SCHOOL PERSONNEL

To be completed by school personnel when administering prescription medication as noted in Sect. I & II

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Personnel	Initials of Student