Appendix A

ORC 3313.713

# AUTHORIZATION TO DISPENSE PRESCRIPTION DRUGS

**(The drug must be received in the original container in which it was dispensed)**

**Student Name** _____

**Student Address** _____

**Student Grade** _____ **Building** _____

**Part I: Parental Request**

I request that the medication described below be administered to _____ (student's name) and grant permission for an authorized individual from St. Henry Consolidated Local Schools to administer the medication. I have read and understand the Board's policy regarding administration of drugs to students.

**Parent Signature** _____ **Date** _____

**Part II: To Be Completed By Physician For Prescription Drugs**

A. **Name of drug** _____ **Dosage** _____

B. **Time Interval for administration:** ____ four hours ____ six hours ____ eight hours

____ before meal ____ after meal ____ with meal

____ other (explain) _____

C. **Medication is to begin on** _____ **and is to end on** _____
**Date** **Date**

D. **Severe reactions which are to be reported to physician and/or parent include** _____

_____

E. **Medication Storage** ____ room temperature ____ refrigerate ____ other _____

F. **Special Instructions** _____

_____

**Signature of Prescribing Physician** _____ **Date** _____