MARLINGTON
LOCAL SCHOOL DISTRICT
ADMINISTRATIVE OFFICES • 10320 Main Ave. NE,
Alliance, OH 44601 • Phone (330) 823-7458
FAX# 823-9594

PHYSICIAN AND PARENTAL CONSENT FOR ADMINISTRATION OF PRESCRIPTION MEDICATION AT MARLINGTON LOCAL SCHOOLS

1. NAME OF STUDENT: _____ AGE: ____
   LAST FIRST MIDDLE
2. STREET: _____ CITY/STATE: _____ ZIP: _____
3. SCHOOL DISTRICT BUILDING: _____ GRADE: _____
4. NAME OF MEDICATION & DOSAGE: _____
5. TIMES AT WHICH MEDICATION IS TO BE GIVEN: _____
6. ADMINISTRATION OF MEDICATION TO BEGIN: _____
7. ADMINISTRATION OF MEDICATION TO END: _____
8. ADVERSE REACTIONS THAT SHOULD BE REPORTED TO THE PHYSICIAN: _____
9. SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF THE DRUG, INCLUDING STERILE CONDITIONS AND STORAGE: _____

NOTE: Only medication in its original prescription bottle labeled with the date of prescription, student's name, and exact dosage will be administered. Any change in information provided by the physician shall require a new consent form and a new original prescription bottle of medication properly labeled. This form must be filled out and signed prior to any medication being administered to any child.

_____ Physician's Phone: _____
Physician's Signature: Date:

_____ Parent's Phone: _____
Parent/Guardian's Signature Date

Adopted: 01-15-85
Revised: 07-13-99

Tradition of Excellence; Commitment to the Future