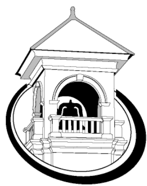

Olney Friends School

61830 Sandy Ridge Road, Barnesville, OH 43713
www.olneyfriends.org

PRESCRIPTION MEDICATION AUTHORIZATION

Student Name:______________________________Birth date:__________________

PART A: TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

Name and dosage of medication to be given. Time medication is to be given.

1)____

2)____

3)____

4)____

5)____

6)____

Possible side effects/ adverse reactions to watch for:

____

____

Physician's Signature: _________________________________Date:_____________

Physician's phone number: ____

PART B: TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give the school nurse or her designee(s) permission to assist my child with his/her prescription medications. I agree to see that the medication is delivered to the school where it will be stored in the infirmary. I agree to notify the school nurse of any changes in medications or dosages.

Medications must be in the original container with the label intact. Refills are to be sent to the school nurse in care of the school. DO NOT send refills to the student.

Parent/Guardian Signature:_______________________________Date:________

This form will expire at the end of the school year or in the event of a medication change.

Phone: 740-425-3655 Fax: 740-425-3202
e-mail: becky@olneyfriends.org