

WAPAKONETA CITY SCHOOLS

THIS SIDE OFFICE USE ONLY

Homeroom Teacher _____

STUDENT _____ SCHOOL Wapakoneta High

MEDICATION _____ DOSE _____

PER DR. _____ AS OF (DATE) _____

PRESCRIPTION / OVER THE COUNTER (CIRCLE ONE)

FOR SCHOOL YEAR 2011-2012

AUG	SEPT	NOV	DEC	JAN	FEB	MAR	MAY
24	28	1	9	25	27	29	7
25	29	2	12	26	28	30	8
26	30	3	13	27	29	APR	9
29	OCT	4	14	30	MAR	2	10
30	3	7	15	31	1	3	11
31	4	8	16	FEB	2	4	14
SEPT	5	9	19	1	5	11	15
1	6	10	20	2	6	12	16
2	7	11	21	3	7	13	17
6	10	14	22	6	8	16	18
7	11	15	JAN	7	9	17	21
8	12	16	3	8	12	18	22
9	13	17	4	9	13	19	23
12	17	18	5	10	14	20	24
13	18	21	6	13	15	23	25
14	19	28	9	14	16	24	29*
15	20	29	10	15	19	25	30*
16	21	30	11	16	20	26	31*
19	24	DEC	12	17	21	27	
20	25	1	17	20*	22	30	
21	26	2	18	21	23	MAY	
22	27	5	19	22	26	1	
23	28	6	20	23	27	2	
26	31	7	23	24	28	3	
27		8	24			4	

*Possible make-up day

Medication sent home (date):
 _____ / _____ / _____

Medication brought in (date):
 _____ / _____ / _____

pills (if applicable):
 _____ / _____ / _____

Signatures/Initials
 _____ / _____

 _____ / _____

 _____ / _____

PARENT OR GUARDIAN REQUEST TO ADMINISTER MEDICATION

As the parent or legal guardian of _____ who attends _____ School, I request that my child be given the medication described below as prescribed by Dr. _____. I understand that this medication will be given by the principal or his/her designee. I also understand that I must submit a revised statement signed by the physician if any of the information originally provided by the physician changes.

1. All medication must be brought to school by parent/guardian.
2. All medication must be received in the original prescription bottle properly labeled by a registered pharmacist as prescribed by law. All medication must be labeled with the student's name, dosage, and the name of the medication.
3. Nonprescription medication (over the counter) will not be administered within the schools by school personnel except with doctor's written orders.

PARENT/GUARDIAN'S NAME (PLEASE PRINT)

SIGNATURE OF PARENT OR GUARDIAN

PARENT/GUARDIAN'S PHONE NUMBER

DATE

PHYSICIAN'S ORDER FOR PRESCRIBED MEDICATION

Both state law O.R.C. and all Wapakoneta City Schools require the following information when children need administration of prescription drugs. Please complete the following information and forward to the school.

1. NAME OF STUDENT _____ DOB _____
LAST FIRST MIDDLE
2. ADDRESS _____
STREET CITY/STATE/ZIP
3. SCHOOL _____ CLASS/GRADE _____
4. NAME OF MEDICATION _____
5. DOSAGE TO BE ADMINISTERED _____
6. TIMES AT WHICH THE MEDICATION IS TO BE ADMINISTERED _____
7. ADMINISTRATION OF MEDICATION TO BEGIN _____ END _____
DATE DATE
8. SIGNIFICANT SIDE EFFECTS (ADVERSE REACTION) WHICH SHOULD BE REPORTED TO THE PHYSICIAN _____
9. SPECIAL INSTRUCTION FOR ADMINISTRATION OF THE DRUG, INCLUDING STERILE CONDITIONS AND STORAGE _____

PHYSICIAN'S SIGNATURE

PHYSICIAN'S EMERGENCY PHONE NUMBER

THERE MUST BE NOTIFICATION TO THE SCHOOL IF ANY INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.

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MEDICATION _____ DOSE _____

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7	11	15	JAN	7	9	17	21
8	12	16	3	8	12	18	22
9	13	17	4	9	13	19	23
12	17	18	5	10	14	20	24
13	18	21	6	13	15	23	25
14	19	28	9	14	16	24	29*
15	20	29	10	15	19	25	30*
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27		8	24			4	

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Medication brought in (date):
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pills (if applicable):
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Signatures/Initials
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WAPAKONETA CITY SCHOOLS

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9	13	17	4	9	13	19	23
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13	18	21	6	13	15	23	25
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27		8	24			4	

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Medication brought in (date):
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Signatures/Initials
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WAPAKONETA CITY SCHOOLS

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12	17	18	5	10	14	20	24
13	18	21	6	13	15	23	25
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15	20	29	10	15	19	25	30*
16	21	30	11	16	20	26	31*
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