Fairview Park City School District
21620 Mastick Rd., Fairview Park, OH 44126 / P: (440) 331-5500 F: (440) 356-3545
Middle/High School Clinic Fax: (440) 356-3529/ **Elementary School Clinic Fax:** (440) 356-3701/ **EEC Clinic Fax:** (440) 356-3544
Superintendent: Keith Ahearn• Treasurer: Rob Showalter

PRESCRIBER AND PARENT/GUARDIAN REQUEST

For Administration of Medication at Fairview Park City Schools

[Medication Administration Record- MAR]

******* One Medication per Form *******

School: _____

Student: _____ Grade: _____

Address: _____

City/State/Zip: _____

Name of Medication: _____

Dosage: _____

Times of Day to be Administered (##:##AM/##:##PM): _____

Number of Times/Intervals Medication is to be Administered: _____

Field Trip/Medication Start Date: _____ Field Trip/Medication End Date: _____

Adverse/Severe Reaction to be Reported to Physician (DO NOT LEAVE BLANK):

_____

Special Instructions for Medication (with/without food/liquid, DO NOT LEAVE BLANK):

_____

This medication can be safely administered by nonmedical personnel? _____YES _____NO

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours/field trip.

Prescriber's Printed Name: _____

Prescriber's Signature: _____

Prescriber's Phone Number: _____ Date: _____

Please regard my signature below as my assurance that I release Fairview Park City Schools, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

Parent's/Guardian's Printed Name: _____

Parent's/Guardian's Signature: _____

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