Ohio School for the Deaf
Student Health Services
500 Morse Road
Columbus, Ohio 43214

Cell/Text: 614-598-1429
Fax: 614-468-8851
Email: OSDSHS@osd.oh.gov

PHYSICIAN STATEMENT

To the Physician:

The Ohio School for the Deaf is a residential school for Ohio's deaf students. We administer medication to our residential students 24 hours a day. It is our policy to have documentation from the student's physician regarding prescription medication brought to school. Therefore, we appreciate your attentiveness to this form. Please complete one form for each medication prescribed.

I verify that the student _____is under my care.

This student has been diagnosed with _____ and has been

prescribed with:_____
(Medication name, dosage, route, and time of day)

Precautions or side effects: _____

_____

Start date: _____ Discontinue date: _____

Physician's Name: _____ Physician's Signature: _____

Address: _____Phone:_____

Parent Authorization

To the parent or guardian:

The following information is necessary for any student who uses prescribed medications while at the Ohio School for the Deaf.

1. I am requesting permission for the student named above to use medication according to the doctor's verification on this form.
2. I will assume responsibility for the safe delivery of the medication to the school, either by myself or by the student. This includes notifying the school nurse of the medication delivery by the student and the amount of medication sent.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I release and agree to hold the Ohio School for the Deaf, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
(Signature of parent or guardian) (Date)