Southern Ohio Learning Center
3321 Airborne Road
Wilmington, OH 937-383-1691

# Provider's Statement for Medication Administration

_____, residing at _____
(student's name) (address)
_____, and a student in the _____ grade at the
(address)
is under my care and must take medication which I have prescribed during the school day.

Name of Medication as it appears on the container it is stored in:
_____

_____

Dosage & Time intervals: _____

Date of Administration to begin: _____

Date of Administration to end: _____

Possible adverse reaction and/or special instructions:
_____

_____

Physician: _____

Primary Phone #_____

Secondary Phone # _____

_____ _____
Physician Signature Date