WOOD COUNTY
EDUCATIONAL
SERVICE CENTER

1867 N. Research Drive Bowling Green, OH 43402
419-354-9010 Fax: 419-354-1146 www.wcesc.org

PATHE / PACE

2024-2025 Registration Packet

Request for Administration of Medication

☐ **Not applicable to my child**

To be completed by Parent:

I hereby request that my child receive medication during the school day as recommended below by our physician. I give permission to the teacher or delegate, to administer the medication to my child.

Student's Name _____ School Building _____

Street Address _____ Class/Grade Level _____

City & Zip _____

Parent's Name _____ Telephone _____

Parent's Signature _____ Date _____

Parent's Address (if different from above) _____

To be completed by Physician:

Physician's Name _____ Telephone _____
Please PRINT

Physician's Address _____

Name of Medication _____ Dosage _____

Date administration is to begin: _____

Date administration is to cease: _____

Administer at the following times each day _____

Provide instructions for administration _____
(i.e.: route, sterile conditions, storing, etc.)

_____

Specify any severe adverse reactions which should be reported to the physician

_____
Physician's Signature Date