Shelby County Board of Developmental Disabilities
1200 S Children's Home Rd Sidney OH 45365
Phone 937-489-4565 Fax 937-498-0085

PHYSICIAN'S CERTIFICATE OF MEDICATION

To the Physician:
This form must be completed by you in order for the named student in our program to have medication administered to him/her. Please send the completed form to the nurse at the above address before any medication can be distributed.

Only those medications listed below will be administered

Student's Name_____ Date of Birth _____

I hereby certify that I have prescribed or directed the above named student to take the following medication(s) as detailed below:

_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End
_____	_____	_____	_____	_____	_____
Medication	Dosage	Route	Time	Begin	End

Special Instructions for administration, including, sterile conditions and storage:

<u>Any adverse reactions shall be reported to the prescribing physician</u>

_____	_____	_____
Physician's Signature	**Date**	**Phone number**
_____	_____	
Physician's Name (Please print)	**Address**	