Medication order 3/19/2015

Dover Sherborn Prescription Medication Administration Form

This form is to be completed by a **physician/prescriber** and parent/guardian before any prescription medication can be administered in school. Each medication requires a separate form. In some cases the original pharmacy container holding the prescribed medication may be used as the physician/prescriber order information if the medication is for short term use only.

PHYSICIAN/PRESCRIBER

Name of Student_____ DOB _____ Grade_____
Medication_____ Dosage_____ Route_____
Frequency_____ Time(s) to be given at school_____
Diagnosis* reason for giving medication: _____
Specific Directions for storage and administration: _____
Date of Order_____ Discontinuation Date_____

(Medication orders for school administration expire at the end of the school year. New orders are required to continue medication into the next school year.)

Possible Side Effects _____
Drug/Food Allergies _____
List additional medication taken at home _____
Name of Licensed Prescriber _____ Title_____
Signature of Licensed Prescriber _____ Date_____
Address_____ Phone _____

PARENT/GUARDIAN

Name of Parent/Guardian_____ Relationship to student_____

____ Yes ____ No I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

I consent to have the School Nurse or school personnel designated by the School Nurse to administer the above medication to my child. I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Signature of Parent/Guardian_____ Date_____

Telephone (home) _____ (work) _____
Cell/Pager_____
Email _____