Medication Order Form

*This form is to be completed by a **physician** and **parent** before any medication can be administered in school.* With parent/guardian permission (found on **Student Registration/Verification Information form**), the school nurse can administer Acetaminophen & Ibuprofen. Other Over-the-Counter medications, such as Bacitracin, Neosporin, Tums, Benadryl, etc. can **not** be given without specific parent/guardian consent and a physician's order.

PHYSICIAN

Name of Student_____ DOB _____ Grade_____

Medication_____ Dosage_____ Route_____

Frequency_____ Time(s) to be given at school_____

(Please Note: *Whenever possible, medication should be scheduled at times other than school hours)*

Possible Side Effects_____

Specific Directions or information for administration: _____

Date of Order_____ Discontinuation Date_____

Diagnosis*_____ Drug/Food Allergies_____

Name of Licensed Prescriber_____ Title_____

Signature of Licensed Prescriber_____ Date_____

Address_____ Phone_____

* If not in violation of confidentiality

PARENT

Name of Parent/Guardian_____ Relationship to student_____
List of Additional Medication taken at home_____

____ Yes _____ No I give permission for my son/daughter to self-administer his/her **Epipen or Rescue Inhaler**, 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 sons/daughter'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_____