MEDICATION ORDER FORM

For Prescription and Over-the-Counter Medication

Physician Please Note: This form is for one child and one drug only. Please use separate sheets for more than one drug and for other family members. *Remember, whenever possible, medication should be scheduled at times other than school hours.*

Name of Student:_____ Date of Birth:_____Grade:_____

TO BE COMPLETED BY LICENSED MEDICAL PRESCRIBER

Name of Medication:_____
Tablet/Capsule Liquid Inhaler Nebulizer Injection Other:_____
Route of Administration:_____Doasage:_____Frequency:_____
Times of Administration (regular school hours):_____
Specific directions or information for administration:_____
Start Date:_____Discontinuation Date: unless otherwise noted*_____
**Please note: Orders are for the current school year only*
Diagnosis for which medication is prescribed:_____
Other medical conditions*:_____
*if not in violation of confidentiality
Special side effects, contraindications, or possible adverse reactions to be observed:_____
Other physician orders concerning this medication administration:_____
Other medication(s) being taken by student:_____
_____

Consent for self-administration of emergency medication. Only emergency medication such as epipen(s) and/or asthma metered dose inhaler for severe asthmatic is allowed. At the discretion of the parent, licensed provider and school nurse, this student may carry and self administer emergency medication listed above,with appropriate follow-up with school nurse/personnel. (*No student may carry or self-administer any psychotropic or controlled medication).* Contract to carry form is to be completed with school nurse.

- ☐ No Self administration
- ☐ May self administer under this condition:_____
- ☐ May self administer unsupervised, with a contract
- ☐ May self administer for field trips only, with supervision

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_____ _____

Printed Name of Licensed Prescriber Signature

Address: _____ Date: _____

Business Phone: _____ Fax#:_____