the education COOPERATIVE

5

Medication Order Form 2019/2020

Must be completed by a licensed prescriber

★★ Please complete one form for each medication to be given at school ★★

Name of Student: _____ **Date of Birth:** _____

Address: _____ **Grade:** _____

Parent/Guardian: _____ **Emergency Phone:** _____

Name of Licensed Prescriber: _____

Prescriber Telephone: _____ **Prescriber Fax:** _____

Medication: _____ **Allergies:** _____

Route of Administration: _____

Dosage: _____ **Frequency:** _____

Time(s) of Administration: _____

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

Specific directions or information for administration: _____

_____

Date of Order: _____ **Discontinuation Date:** _____

Diagnosis*: _____

* If not in violation of confidentiality.

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed: _____

_____

2. Other medication being taken by the student: _____

_____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

Physician

Consent for Self-Administration (provided the school nurse determines it is safe and appropriate) **Yes_____ No___**

_____

Signature of Licensed Prescriber and date

Parent/Guardian

I understand that 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 the termination of the order or one week beyond the close of school.*

Consent for Self-Administration (provided the school nurse determines it is safe and appropriate) **Yes_____ No___**

_____

Signature of Parent/Guardian and date