

### Medication Order Form 2020/2021

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