DEPARTMENT OF NURSING

SCHOOL NURSE

LICENSED PRESCRIBER

MEDICATION ADMINISTRATION REQUEST
(Forall prescription ,~ non-prescription medication)

Student _____ _ Date of Birth: _____ Grade: _____ _

Medication _____ Dosage: _____ Route: _____ _

Frequency: _____ Time(s) of Administration in school: _____ _

Specific directions or information for administration: _____
_____:

Side Effects: _____ ~ _____ _

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

(Please note: Whenever possible, medication should be scheduled at times other than school hours)
Consent for self-administration (provided the school nurse determines it is safe and appropriate). Yes __ No _____ _

Diagnosis, _____ Other medical conditions, _____
(If not in violation of confidentiality) (If not in violation of confidentiality)

_____ _____
Printed Name of Physician Signature of Physician

PARENT/GUARDIAN

My son/daughter has the following food or drug allergies: _____

I consent to have the school Nurse administer the medication prescribed by the above licensed prescriber
__ Yes __ No

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

I give permission to the School Nurse to share information relevant to the prescribed medication as he/she determines appropriate.
__ Yes __ No

I have read the following requirements for medication administration by the School Nurse:
Medication must be in the original prescription bottle and properly labeled.
Students under the age of 18 are not allowed to carry/transport any medication including Tylenol to and from school.
ParenUGuardian must bring in the medication and pick it up at the end of the school year. State law mandates any medication not picked up must be destroyed.

Medication orders are in effect for the present school year/summer school program only.

Parent/Guardian Signature _____ . _____ Date _____ _

Medication Physician Order / Medication Parent Permission Form