

Medication Order and Parent/Guardian Consent

Name of Student: _____ Date of Birth: _____ Grade _____

Name of Parent/Guardian: _____

Student Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of Prescriber: _____ Phone: _____

Address: _____

Medication: _____ Dose: _____ Route: _____

Time given at school: _____ Start date: _____ End date: _____

Diagnosis: _____ Allergies: _____

Other medications taken by student*: _____

- I give permission to the nurse at school to administer this student the medication on this order.
- I give permission for the nurse at school to share with appropriate school staff information relative to the prescribed medication administration as deemed necessary
Yes _____ No _____
- I give permission for this student to self-administer medication if the nurse at school determines it is safe and appropriate (inhalers, EpiPen, insulin only).
Yes _____ No _____
- I give designated school personnel permission to administer this medication on a field trip during this school year (scheduled medications, inhalers and EpiPen only).
Yes _____ No _____
- I give permission for the nurse at school to share information with the prescriber about my child and this medication. Yes ___ No ___

Parent/Guardian
Signature: _____ Date: _____

Prescribing Provider
Signature: _____ Date: _____

* If not in violation of confidentiality