

# MEDICATION ORDER

## Parent/ Guardian Consent

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

Other medication my child is taking\* \_\_\_\_\_

Allergies \_\_\_\_\_ Health Care Provider \_\_\_\_\_

- I give permission to the nurse at school to administer this medication to my child.
- I give permission for my child to self-administer this medication if the nurse determines it safe and appropriate. (applicable to inhalers, EpiPens & insulin) Yes \_\_\_\_\_ No \_\_\_\_\_
- I give permission to the nurse to share with appropriate school personnel information relative to the prescribed medicine administration. Yes \_\_\_\_\_ No \_\_\_\_\_
- I give designated school personnel permission to administer medication on a field trip if allowable by MDPH guidelines (scheduled medication, EpiPens and inhalers only) Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Licensed Prescriber Order

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Business Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Medication & Dose \_\_\_\_\_ Route \_\_\_\_\_

Frequency \_\_\_\_\_ Time of administration at school \_\_\_\_\_

Start Date \_\_\_\_\_ Discontinue Date \_\_\_\_\_

Side effects, contraindications or possible adverse reactions to be observed \_\_\_\_\_

Consent for self-administration (if school nurse deems appropriate & permitted by MDPH) Yes \_\_\_\_\_ No \_\_\_\_\_

Other medications taken by student\* \_\_\_\_\_

Signature of Licensed Prescriber \_\_\_\_\_ Date \_\_\_\_\_

\*if not in violation of confidentiality