MEDICATION ORDER

Parent 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 have the school nurse or school personnel designated by the school nurse give my child the medication ordered below.
- I give permission for my child to self-administer medication if the nurse determines it safe and appropriate. 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 said medication on a field trip through the duration of this consent form. 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 the school nurse determines it is appropriate). Yes_________No__________

Other medications taken by student*____

Signature of Licensed Prescriber____Date________________

*if not in violation of confidentiality