

PHYSICIAN ORDER FORM FOR MEDICATIONS

TO: _____ FOR: _____ Date of Birth _____ Age _____
Physician's Name (Please Print) Student's Name

Physician's Address School Grade

Physician's Telephone Parent(s)/Guardian's Name(Please Print) Parent/Guardian Telephone

PARENTS/GUARDIANS ARE ADVISED TO GIVE MEDICATIONS AT HOME ON A SCHEDULE OTHER THAN DURING SCHOOL HOURS IF POSSIBLE.

This form must be filled out at the beginning of each school year for any student who must take daily medication during school hours for an extended period of time (e.g. more than two weeks). This also applies for any PRN medication that must be administered for a life threatening situation. Example: Epi-Pen for severe allergic reaction, glucagon for low blood sugar crisis, inhaler or nebulizer treatments for asthma attack. If any change in medication or dosage takes place, a new form must be completed.

NOTE: Both physician's and parent's signatures are required at the bottom of the form.

Physician Only
Use one form for each medication

NAME OF MEDICATION: _____

DOSAGE: _____

EXPECTED TIME OF ADMINISTRATION: _____

METHOD OF ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS: _____

ALLERGIES: _____

This medication must be given during school hours for the treatment of: _____

Other Instructions: _____

Physician's Signature: _____ Date: _____

Parent Permission Statements

I give permission for the school nurse or designee to administer the above medicine to my child at school as prescribed above.

I also give permission for the school nurse to contact the above prescribing physician/health care provider to exchange information regarding my child's health status if necessary.

Parent/Guardian Signature: _____ Date: _____

Please return this form to the school office