Medication Order Form

A provider order and parent/guardian permission are required for all medications administered at school and/or school sponsored activities. **This medication order is valid for a period of one year.**

**Student Name_________________________**  **DOB_________________**  **Grade/Class________**

**Health Care Prescriber Medication Order:**

**Diagnosis:** ________________________________________________________________

**Medication:** ______________________________________________________________

**Dose & Route:** ______________________________________________________________

**Time:** ________________________________________________________________

Additionally, provider attestation and parent/guardian permission are required for a student to independently carry and use a medication such as **inhaled respiratory rescue medication**, epinephrine auto injector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration.

**Provider Permission for Self-Administration and Carry:**

☐ No  ☐ Yes, I attest that this student has demonstrated that he or she can self-administer the medication(s) listed above effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support are needed only during an emergency.

**Provider’s Signature______________________________________________________**  **Date________________________**

**Provider’s Name_________________________________________________________**

**Provider’s Address________________________________________________________**

**Phone____________________________________________________ Fax________________**

**Provider Stamp**

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**Parent/Guardian Permission for Medication**

Review and sign only one of the following:

**Option A. For a student with provider permission to self-administer and carry.**

☐ I agree that my child can self-administer and will carry the medication as prescribed above.

**Parent/Guardian Signature________________________________**  **Date________________________**

**OR**

**Option B. For a student without provider permission to self-administer and carry. (See above.)**

☐ I give permission for my child to receive the medication prescribed above. I understand that I must bring the medication to the school nurse in the original pharmacy or over the counter container.

**Parent/Guardian Signature________________________________**  **Date________________________**