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 __________________

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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 ______________________