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: Adam

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____________________

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____________________