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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

****

Parent/Guardian Permission for Medication

Review and sign <u>only one</u> of the following:

Option A. For a student <u>with</u> 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 <u>without</u> 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_____