

DEPARTMENT OF NURSING

SCHOOL NURSE

LICENSED PRESCRIBER

MEDICATION ADMINISTRATION REQUEST (For all prescription, ~ non-prescription medication)

Student _____ Date of Birth: _____ Grade: _____

Medication _____ Dosage: _____ Route: _____

Frequency: _____ Time(s) of Administration in school: _____

Specific directions or information for administration:

Side Effects: _____ ~ _____

Date of Order: _____ Discontinuation Date: _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Consent for self-administration (provided the school nurse determines it is safe and appropriate). Yes ___ No _____

Diagnosis, _____ Other medical conditions, _____

(If not in violation of confidentiality) (If not in violation of confidentiality)

Printed Name of Physician (legibly)

PARENT/GUARDIAN
Signature of Physician

My son/daughter has the following food or drug allergies: _____

I consent to have the school Nurse administer the medication prescribed by the above licensed prescriber ___ Yes ___ No

I give permission for my son/daughter to self-administer medication, if the School Nurse determines it is safe and appropriate.
___ Yes ___ No

I give permission to the School Nurse to share information relevant to the prescribed medication as he/she determines appropriate.
___ Yes ___ No

I have read the following requirements for medication administration by the School Nurse:

Medication must be in the original prescription bottle and properly labeled.

Students under the age of 18 are not allowed to carry/transport any medication including Tylenol to and from school.

Parent/Guardian must bring in the medication and pick it up at the end of the school year. State law mandates any medication not picked up must be destroyed.

Medication orders are in effect for the present school year/summer school program only.

Parent/Guardian Signature _____ . _____ Date _____

Medication Physician Order / Medication Parent Permission Form