ANNAPOLIS AREA CHRISTIAN SCHOOL PARENT REQUEST TO ADMINISTER MEDICATION AT SCHOOL AND PHYSICIAN ORDER FORM

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

Name of School:		FOR COMPLETION BY PA	AKEN I/GUAKDIAN		
(LAST) (FIRST) (MI) Name of School: School Year:	Name of Student:	3		D.O.B:	
In order for my child to receive medication in school, I agree to the following: * All prescription and non-prescription medication will have a physician's signed order fully completed for each school year. * The prescription medication will be in a container labeled by the physician with: * Name of child Name of physician will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not observe the business the put on the container in a position that does not observe the put on the container will be put on the container in a position that does not observe the put on the container will be put on the container in a position that does not observe the put of the container will be put on the container in a position that does not observe the put of the container will be put on the container in a position that does not observe the put of the container in a position of the does not observe the physician will be called if a question arises about my child's medication. **The physician will be called if a question arises about my child's medication. **The first does of this medication (except for Epi-Pen) has been given without problems. **Having read the above conditions, I request Annapolis Area Christian School personnel administration of medication at school. **Q.**Signature of Parenti*Guardian: **Physician will be called if a question and above, including the administration at School. **Other:** **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM **Date:** **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM **Date:** **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ON		(FIRST)	(MI)		
* All prescription and non-prescription medication will have a physician's signed order fully completed for each school year. **The prescription medication will be in a container labeled by the pharmacist or physician with: **Name of child** **Name of physician physician with: **Name of physician physician will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label. **The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label. **The medication will be called if a question arises about my child's medication. **The first does of this medication (except for Epi-Pen) has been given without problems. **Hawing read the above conditions, I request Annapolis Area Christian School personnel administrate the medication at school. **Sk Signature of Parent/Guardian: **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL. **ONE MEDICATION PER FORM* **Diagnosis: **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL. **ONE MEDICATION PER FORM* **Diagnosis: **Dosage: **Itime of Administration at School: **Itime of	Name of School:			Grade:	School Year:
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Name of physician	* The prescription medication will be in a cor	ntainer labeled by the pharmacist o	r physician with:	School year.	
* The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label. * The medication will be brought to school by an adult. Students are not to handle medications! * The physician will be called if a question arises about my child's medication. * The first dose of this medication (except for Epi-Pen) has been given without problems. * Handing read the above conditions. I request Annapolis Area Christian School personnel administration at school. * Substitution of the physician below. I certify that I have legal authority to consent to medical freatment for the student named above, including the administration of medication at school. * Substitution of the physician below. I certify that I have legal authority to consent to medical freatment for the student named above, including the administration of medication at school. * Substitution of the physician below. I certify that I have legal authority to consent to medical freatment for the student named above, including the administration of medication at school. * Physician's SigneD ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM Diagnosis: **PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM Diagnosis: **Dosage:** Physician's SigneD ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM Physician's School:** Physician's School:** Physician's School:** Physician's Signature:**					
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The physician will be called if a question arises about my child's medication. The first does of this medication (except for Epi-Pen) has been given without problems. Having read the above conditions, I request Annapolis Area Christian School personnel administration of medication at school. See Signature of ParentiGuardian: Phone #: (H): PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM Diagnosis: PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM Diagnosis: Itime of Administration at School: Itime of Administration at School: PERSON Time of Administration at School: PERSON Time of Administration at School: PHONE of the aware of or any unusual effects that might be observed. Services should begin (Date) FOR INHALER, EPI-PEN, and INSULIN ONLY: It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used. It has been determined that this student is able to self-administer insulin. This student should not self-administer inhalant medication, Epi-pen or insulin. Physician's Signature: Physician's		are original couled container was a			
The first dose of this medication (except for Epi-Pen) has been given without problems. It was above conditions, I request Annapolis Area Christian School personale administration as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. Signature of Parent/Guardian: Relationship to student Phone # (H): PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM Diagnosis: Name of medication: Dosage: (mg, ml, ml/tsp, # of purfis) Route: Time of Administration at School: If PRN, for what symptoms? How often? Please list any specific precautions personnel should be aware of or any unusual effects that might be observed. Services should begin (Date) FOR INHALER, EPI-PEN, and INSULIN ONLY: It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used. It has been determined that this student is able to self-administer insulin. This student should not self-administer inhalant medication, Epi-pen or insulin. Physician's Signature: Physician's Signature: Physician's Name (Printed): (original, no stamp)			dle medications!		
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Relationship to student	Having read the above conditions, I request Annap	olis Area Christian School personnel ad	dminister the medication as prescrib	ed by the phys hool.	ician below. I certify that I have
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PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL ONE MEDICATION PER FORM Diagnosis: Name of medication: Dosage:	Relationship to student				
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Route: Time of Administration at School: Lunchtime If PRN, for what symptoms? How often? Please list any specific precautions personnel should be aware of or any unusual effects that might be observed Services should begin (Date) and terminate (Date) FOR INHALER, EPI-PEN, and INSULIN ONLY: It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used. It has been determined that this student is able to self-administer insulin. This student should not self-administer inhalant medication, Epi-pen or insulin. Physician's Signature: Physician's Name (Printed): Address: Physician's Name (Printed):					
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__ R.N. Date

Order Reviewed