



Physician's Orders for Medication at School

Patient: _____ Date of Birth: _____

Medication should be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the Health Room Assistant will dispense the medication. The principal will designate the person responsible to dispense medication on an individual basis. The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Is it necessary to dispense this medication during school hours? ____ Yes ____ No

If yes, please give diagnosis or reason: _____

Drugs and dosage form: _____

Dose and mode of administration: _____

Time(s) to be given: ____ Lunch ____ Hour _____

Duration without subsequent order: ____ Weeks ____ School Year

Side effects of drug (if any) to be expected: _____

Medication to be carried by student: ____ Yes ____ No

Physician Signature: _____ Print or Stamp Name: _____

Date: _____ Phone: _____

Parent's Permission

I request that the school nurse, principal, or a staff member designated by him/her be permitted to dispense to my child, (name of child) _____, the medication prescribed by (name of physician) _____, for a period from _____ to _____.

- The medication to be furnished is to be brought in by me in the original container labeled by the pharmacy or physician with the child's name, name of the medicine, the amount to be taken, the time of day to be taken, and the physician's name.
• I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions.
• This authorization is good for the current school year only.
• In case of necessity, the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.
• I give permission to the school nurse to consult my child's health care provider with any concerns about medication related issues and I release school personnel from liability should reactions result from the medication.

Signature of Parent/Guardian: _____ Date: _____

Parent's Home Phone: _____ Work Phone: _____ Cell Phone: _____