Physician Order for Prescription Medication in School
2021-2022

Student Name: _____

_____

Grade: _____ Birth Date: _____ ☐ Returning student ☐ New Student

Dear Haverford Parent,

Please ask your son's physician to complete this form for an EpiPen, inhaler, insulin, and/or any other prescription medication your son may require during school/activity hours.

Please return this form to the School Health Center, along with the medication in its original container, prior to your son's first day of school. If your son participates in athletics, please supply medication to keep in the athletic training room as well. Should your son need to carry a life-saving medication, he must meet with the School Nurse prior to use to discuss the safety and proper use of the medication.

To be completed by the **Physician**:

Medication Name: _____ Dose: _____

Reason for Medication: _____

Time to Administer (if applicable) _____ Frequency: _____

☐ PRN for the following symptoms _____

☐ 15-20 minutes prior to exercise

Route: ☐ PO ☐ Topical ☐ Inhaled ☐ Nebulized ☐ SQ ☐ IM ☐ Other _____

Start date: _____ Stop date: _____

☐ This student has my permission to carry this medication in school **(applies only to life-saving medications)**

☐ This medication must be available during athletics

Physician Signature: _____ Date: _____

Office Stamp:

PLEASE UPLOAD TO YOUR MAGNUS HEALTH ACCOUNT - PRESCRIPTION MEDICATION FORM REQUIREMENT SECTION