



Orono Schools Health Services
Administration of Medication At School Request Form

School Year: _____

Daily:_____ **As Needed:**_____

Parents of a student requesting that medication be administered during school hours by school staff are required to provide for the school: **1) the physician order**, **2) a parental release** and 3) medication supplies in the **original medication bottle** (*you may ask the pharmacy for medication to be split between two labeled bottles*).

Student name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Physician's Order for Administration of Medication by School Personnel

I have prescribed the following medication and request the dosages to be given during school hours:

Medication: _____ Dosage to be given: _____

Unit dose (strength) provided: _____ Time to be given: _____

For treatment of: _____

Possible side effects: _____

Special instructions: _____

Last dose to be given (date): _____

If this medication is for a potentially life threatening condition, please include emergency action plan from the physician.

Physician's Signature: _____ Phone: _____ Date: _____

Physician's address or clinic name: _____

Parental Request for Administration of Medication and Release of Information

Only when a medication is prescribed to be taken during school hours will a child be given medication at school. I request this medication to be given as prescribed and the above requested information to be released to the physician from the school. If necessary the school may request additional information from the physician regarding this medication/condition.

Parent/Guardian Signature: _____ Date: _____

Schumann Elementary Health Office	Phone: (952) 449-8487	Fax: (952) 449-8499
Orono Intermediate School Health Office	Phone: (952) 449-8473	Fax: (952) 449-8479
Orono Middle School Health Office	Phone: (952) 449-8461	Fax: (952) 449-8453
Orono High School Health Office	Phone: (952) 449-8417	Fax: (952) 449-8449

For School Health Office Use Only

Date Medication Received	Unit Dosage	Count	Expiration Date	Initials of Person Receiving

Initials

Signature

