PHYSICIAN ORDER AND MEDICATION AUTHORIZATION FORM

(Please complete every item on this form.)

Student's Name:____

Date of Birth: ______________________ School: ______________________

PHYSICIAN'S ORDER AND STUDENT COMPETENCY STATEMENT

1. I have examined this student for (diagnosis) ______________________ and have determined she/he requires medication during school hours.
2. Name of medication: ______________________ Dosage: ______________________

   Generic substitution is permitted: ________YES ________NO
3. Time of administration: ______________________
4. This student is expected to be receiving this medication (how long?): ______________________
5. Special instructions regarding this medication: ______________________
6. Contact me if the following signs or symptoms appear: ______________________

I believe this student is able to carry and administer her/his own medication (excluding controlled substances) at the appropriate time and in the appropriate way. Please check ____YES ____NO

Physician's Signature: ______________________ Printed Name: ______________________

Date: ______________________ Phone: ______________________

PARENT/GUARDIAN STATEMENT (Please complete the appropriate statement below.)

1. I/We, the undersigned parent(s)guardian(s) of ______________________, believe she/he is competent to carry and administer her/his own medication (excluding controlled substances) at the appropriate time and in the appropriate way. I/We give my/our permission for her/him to do so.
2. I/We, the undersigned parent(s)/guardian(s) of ______________________, request that a school employee assist the student with the self-administration of the above medication, according to the physician's instructions. I/We agree to furnish the necessary prescribed medicine in the properly labeled container, to provide replacement medication as necessary, and I/we agree to notify the school nurse immediately if the physician or medication prescription is changed.
3. FOR STUDENTS WHO HAVE A DISABILITY THAT PREVENTS THEM FROM SELF-ADMINSTRATION: I/We, the undersigned parent(s)/guardian(s) of______________________, request that a school nurse administer the above medication, to the student, according to the physician's instruction. I/We agree to furnish the necessary prescribed medication and I/we agree to notify the school nurse immediately if the physician or medication prescription is changed.

Parent/Guardian Signature: ______________________ Date: ____________

Home Phone: ______________________ Work: phone: ______________________

Medication discontinued per: parent_______(physician notified:_____Date:____________)
Medication discontinued per: physician_____Date:______________________