

AVONWORTH SCHOOL DISTRICT
Medication Order for Administration in School

To be completed by licensed prescriber:

Date: _____

Student's Name:		Grade/Homeroom:
Medication Name	#1	#2
Dosage & Route		
Time of Administration		
Length of Administration	Start Date _____ Stop Date _____	Start Date _____ Stop Date _____
Reason for Medication		
Administration Instructions		
Side Effects		
Field Trips	Please <u>check one</u> of the following options when a parent/guardian or parent/guardian designee (non-staff) is unable to attend a field trip: _____ Yes, the prescribed dose can be withheld on the day of the field trip. _____ Yes, the time can be adjusted with a parent to be administered upon return to school. _____ No, this medication must be given to the child at the prescribed time. Explain: _____	
Competency for Self Administration (ONLY for inhaler or auto-inject epinephrine)	I, _____, certify that this student has a potentially life threatening illness and (licensed prescriber's printed name) requires an inhaler or auto injecting epinephrine. This student is competent and has been instructed in the proper method of self administration of said medication. This student may therefore carry and self-administer his/her inhaler or auto injecting epinephrine.	
Signature of Licensed Prescriber	_____ Phone: _____ (Not valid without licensed prescriber signature)	

To be completed by Parent/Guardian:

I give permission for my child to receive the above noted medication at school. I waive and release the District and any District employee from any and all liability or responsibility for the administration of the medication or benefits or consequences of the medication and acknowledge that the District bears no responsibility for ensuring that the medication is taken. I also give my permission for the school nurse to contact the licensed prescriber, as necessary, regarding the medication.

Parent/Guardian Signature: _____ Date: _____
(Not valid without signature)

If there is a two hour delay of opening school:

_____ Yes, administer my child's medication as prescribed

_____ No, I will contact you if the time is to be adjusted