Richmond County Schools
MEDICATION OR PROCEDURE ORDER FORM

STUDENT NAME: _____ D.O.B: _____

SCHOOL: _____ GRADE/TEACHER: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER

DIAGNOSIS: _____

MEDICATION / PROCEDURE: _____

_____

DOSAGE: _____ ROUTE: _____

TIME OF ADMINISTRATION: _____

SPECIAL INSTRUCTIONS: _____

_____

DATES TO BE PERFORMED (Maximum of 1 year): _____

FOR SELF-ADMINISTRATION

☐ YES ☐ NO - Student has demonstrated understanding of and ability to self-administer above medication for asthma, diabetes, or anaphylactic reaction and may carry and self-administer as prescribed.

PRESCRIBED BY: _____ DATE: _____
(Signature of Healthcare Provider)

Print name: _____ Providers Phone #: _____

PARENT / GUARDIAN PERMISSION

I hereby authorize the designated staff to administer the prescribed medication/procedure as directed above. I hereby release the School Board and their agents and employees from all liability that may result from my child receiving the prescribed medication/procedure. I hereby authorize the school staff and above Healthcare provider to share information relative to the health of my child named above.

Parent /Guardian Signature _____ Phone _____ Date: _____

School Nurse Signature _____ Date: _____