

**MEDICATION ADMINISTRATION FORM**  
**THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS**  
 Provider Medication Order Form | Office of School Health | School Year **2026-2027**

<b>Student Last Name</b>	<b>First Name</b>	<b>Middle</b>	<b>Date of birth</b> ___/___/___ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>School</b>			<b>Grade</b>	

**HEALTH CARE PRACTITIONERS COMPLETE BELOW**

<p><b>1. Diagnosis:</b> _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p><b>Medication:</b> _____ Generic and/or Brand Name</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p><b>Student Skill Level (Select the most appropriate option):</b></p> <p><input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication</p> <p><input type="checkbox"/> Supervised Student: student self-administers, under adult supervision</p>	<p><b>In School Instructions</b></p> <p><input type="checkbox"/> Standing daily dose: at ___:___ AM / PM and ___:___ AM / PM <b>AND/OR</b></p> <p><input type="checkbox"/> PRN _____ specify signs, symptoms, or situations</p> <p><input type="checkbox"/> Time interval: ___ minutes or ___ hours as needed.</p> <p><input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>
<p><b>2. Diagnosis:</b> _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p><b>Medication:</b> _____ Generic and/or Brand Name</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p><b>Student Skill Level (Select the most appropriate option):</b></p> <p><input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication</p> <p><input type="checkbox"/> Supervised Student: student self-administers, under adult supervision</p>	<p><b>In School Instructions</b></p> <p><input type="checkbox"/> Standing daily dose: at ___:___ AM / PM and ___:___ AM / PM <b>AND/OR</b></p> <p><input type="checkbox"/> PRN _____ specify signs, symptoms, or situations</p> <p><input type="checkbox"/> Time interval: ___ minutes or ___ hours as needed.</p> <p><input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>
<p><b>3. Diagnosis:</b> _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p><b>Medication:</b> _____ Generic and/or Brand Name</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p><b>Student Skill Level (Select the most appropriate option):</b></p> <p><input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication</p> <p><input type="checkbox"/> Supervised Student: student self-administers, under adult supervision</p>	<p><b>In School Instructions</b></p> <p><input type="checkbox"/> Standing daily dose: at ___:___ am / pm and ___:___ AM / PM <b>AND/OR</b></p> <p><input type="checkbox"/> PRN _____ specify signs, symptoms, or situations</p> <p><input type="checkbox"/> Time interval: ___ minutes or ___ hours as needed.</p> <p><input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>

<b>Health Care Practitioner (Please Print)</b>	<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>Signature</b>
<b>Address</b>		<b>Tel. No.</b> (____)____-____	<b>Fax. No.</b> (____)____-____
<b>E-mail address</b>		<b>Cell phone</b> (____)____-____	
<b>NYS License No (Required)</b>		<b>NPI No.</b>	<b>Date</b> ___/___/___

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**THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS**

**PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year **

**PARENTS/GUARDIANS FILL BELOW**

**By signing below, I agree to the following:**

- I consent to my child’s medicine being stored and given at school based on directions from my child’s health care practitioner.
- I understand that:
  - o I must give the school nurse my child’s medicine.
  - o All prescription and “over-the-counter” medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
    - Prescription medicine must have the original pharmacy label on the box or bottle.
  - o No student is allowed to carry or give him or herself controlled substances.
  - o I must immediately tell the school nurse about any change in my child’s medicine or the doctor’s instructions. I will give my child’s school nurse a new medication administration form written by my child’s health care practitioner.
  - o The medication order in this medication administration form expires at the end of my child’s school year. I will give my child’s school nurse a new medication administration form at the beginning of every school year.

<b>Student</b> Last Name	First	Date of Birth ___ / ___ / _____
<b>Parent/Guardian</b> Print Name:		Signature:
Date Signed ___ / ___ / _____		Cell Phone:
Other Phone:		Email: