

## Physician's Orders for Medication at School

| Student Information   |                        |              |
|-----------------------|------------------------|--------------|
| Name:                 | DOB:                   | School Year: |
| Parent/Guardian Name: | Parent/Guardian Phone: |              |

| Medication Information                                                                                                                                                                                                                          |                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Medication:                                                                                                                                                                                                                                     | Dosage/strength:                                                                 |
| Route: <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Eye drops <input type="checkbox"/> Ear drops <input type="checkbox"/> Nasal spray <input type="checkbox"/> IM Injection <input type="checkbox"/> |                                                                                  |
| Frequency/time to be given:                                                                                                                                                                                                                     | Duration: Start                      End<br>(Valid for current school year only) |
| Reason/diagnosis:                                                                                                                                                                                                                               |                                                                                  |
| Side effects (if any) to be expected:                                                                                                                                                                                                           | Action to take if occurs:                                                        |
| Special instructions/precautions:                                                                                                                                                                                                               |                                                                                  |
| Medication to be carried by student? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                   |                                                                                  |

| Licensed Health Physician Authorization                                                                                                                  |        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| <input type="checkbox"/> I certify that this student requires the above medication to be administered during school hours or at school-sponsored events. |        |
| Name:                                                                                                                                                    | Date:  |
| Signature:                                                                                                                                               | Phone: |

| Parent/Guardian Authorization                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| I request that the above medication be administered to my child as prescribed. I understand that: <ul style="list-style-type: none"> <li>• Medication must be in the original labeled container;</li> <li>• I will deliver medication directly to school staff (students should not transport medication except for emergency medications);</li> <li>• No more than a 20-day supply should be provided;</li> <li>• Authorization is valid only for the current school year; and</li> <li>• The district may discontinue medication administration with proper notice.</li> </ul> |       |
| Signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Date: |

| FPS Office Use Only                                                                                |                                                                           |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Medication received by:                                                                            | Date:                                                                     |
| Storage location: <input type="checkbox"/> Health room <input type="checkbox"/> Student self-carry | Initial count: <input type="checkbox"/> Pills <input type="checkbox"/> mL |